Maternal and Child Health Services
Title V Block Grant

State Narrative for California

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The State of California's Assurances and Certifications and Memorandums of Understanding are available on request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

>Facilitating Comment on the FFY 2011 Title V Report/Application and the 2011-2015 Needs Assessment Report
To generate awareness, stakeholders and partners were informed that public comment will be sought regarding the FFY 2011 Title V Report/Application and the 2011-2015 Needs Assessment Report. These announcements were made during meetings with stakeholder and advisory groups a few weeks prior to the reports were released. Since the full reports were long and extensive and too lengthy for the public, MCAH developed abridged versions of both reports. Sections included in the 58-page draft FFY 2011 Title V Report/Application for public comment were a state overview, including major state initiatives; agency capacity; impact of the state budget cuts on programs; and, data on national and state performance measures and health capacity and status indicators. Included in the 126-page draft 2011-2015 Needs Assessment Report for public comment were, an overview of social determinants of health; data presenting the health status of the MCAH population; health insurance and healthcare utilization, a discussion on the impact of the state budget cuts to MCAH programs and the priority needs that were identified during the needs assessment process. Both reports were posted on the MCAH website (http://www.cdph.ca.gov/programs/mcah/Pages/MCAH-TitleVBlockGrantProgram.aspx)

The Children's Medical Services (CMS) Branch added a link on the CMS website that connected to the MCAH website and the draft Application/Report, making it available to its partners. CMS posted the full version of the Children with Special Health Care Needs (CSCHCN) Needs Assessment report online.

An e-mail was sent to agencies, organizations, and stakeholder groups targeted for comment or input. MCAH also sought comment from potential stakeholders including the Maternal Childe Health Bureau (MCHB)-funded California principal investigators listed on the MCHB website (http://www.mchb.hrsa.gov/RESEARCH/projects.asp) A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Children's Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.

Stakeholders were given 2 weeks to provide comment either by phone or e-mail. Most comments were submitted when a reminder e-mail was sent out MCAH responded to each person/entity providing comment.

Comments were received from 27 professionals representing local MCAH programs, offices or programs from various state departments, academia, a health maintenance organization, a professional medical association, a parent and family advocacy organization and a health policy organization.. Seventy percent of those who provided comment acknowledged the great amount of effort that was invested in creating the reports and/ or the high quality and thoroughness of the reports posted for public comment. Responses to HRSA comments in last year's review is included in an attachment.

Themes that emerged from the comments received include constructive suggestions to elaborate on certain health issues or programs that address the needs of the MCAH population, barriers and opportunities for program enhancement, as well as technical edits. Input received in response to the draft reports will be considered and will have its greatest impact during MCAH's strategic planning process.

/2012/
>Facilitating Comment on the FFY 2012 Title V Report/Application

A similar method as described above was adopted to facilitate public comments on the FFY 2012 Title V report/application. A public document was circulated to more than a hundred stakeholders for comment, including those representing tribal organizations. Comments were received from 9 professionals representing local MCAH programs, and offices, academia and a professional medical association. //2012//

/2013/
>Facilitating Comment on the FFY 2013 Title V Report/ Application

A similar method as described above was adopted to facilitate public comments on the FFY 2013 Title V report/application. A public document was circulated to several hundred stakeholders for comment, including those representing tribal organizations. More than 30 comments were received from providers, progam clients and local MCAH directors. //2013//

> Facilitating Input on Programs
Public input is a valuable tool to increase program success and improve services. Input from community members and families have been sought through each of the 61 local needs assessments conducted by MCAH local health jurisdictions (LHJs). Activities related to the local needs assessment and capacity assessment is a form of soliciting public input. Most MCAH LHJs reported that they conducted community meetings, forums and focus groups. These provided the community an opportunity to voice concerns relevant to MCAH health and health care services currently available in the state.

All MCAH-funded programs have a program advisory or workgroup that were formally created. Through regular teleconferences and face-to-face meetings scheduled throughout the year, these advisory or work group members provide voice for program users or clients who tap into the services provided by MCAH programs. Recommendations and input from these groups generally serve to reaffirm our current activities and plans as well as introduce some valuable new ideas such as identifying emerging issues and provide useful feedback for program and policy development.

All MCAH programs systematically and conscientiously make every effort to encourage consumers of program services to give voice to their concerns or provide suggestions on how the

quality and effectiveness of MCAH Program can be improved. Most of these are conducted through satisfaction surveys. Results of these surveys are routinely reported in annual reports by local program agencies which is submitted to MCAH. MCAH staff invites input on an ongoing basis via phone, e-mails or through listservs. The MCAH webpages provide a mechanism for the public to e-mail inquiries and comments directly to MCAH.

MCAH stakeholders and partners are kept apprised of changes in federal legislation and the impact of these changes on MCHB Title V funding, recommendations and requirements. Updates are provided via conference calls, in-person meetings or program newsletters with all MCAH partners including but not limited to meetings for the Preconception Health Council of California (PHCC), the MCAH Action Committee, the Adolescent Sexual Health Workgroup (ASHWG), the California Perinatal Quality Care Collaborative and California Maternal Quality Care Collaborative Executive Committees and the Regional Perinatal Programs of California (RPPC).

An attachment is included for this section.
An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Emerging issues and changes to MCAH and CMS programs and system capacity as they relate to priority needs are described below.

> Modify the CCS program, with appropriate funding, to cover the whole child.

This is partly addressed by the 1115 waiver's Bridge to Reform". Five project demonstration sites were selected with 4 different models of care through which CCS children will have all their care needs met through a single coordinated health system. The models are: Utilization of Medi-Cal Managed Care Plans (MCMC), Specialty Health Care Plan (SHCP), Enhanced Primary Care Case Management (EPCCM), and Provider-based Accountable Care Organization (ACO). These innovative models have projected phase-in start dates anticipated for late 2012 through 2013.

The 1115 Evaluation Oversight Committee is a y team of key CCS leaders, Medical Consultants, and stakeholders representing facilities, providers and family advocacy groups. The evaluation program is being developed by the University of California at Los Angeles (UCLA), Center of Health Policy Research and will include rapid determination of any areas which require more attention, and extensive family and providers' satisfaction to access, integration of care, and identify barriers to reform.

> Expand the number of qualified providers of all types in the CCS program.

CCS is addressing the shortage of both pediatric subspecialty physicians and facilities approved for care of CCS clients. There were significant compromises in maintaining a provider network for CCS patients which is currently barely adequate to meet the needs. However, nearly a 10% increase in designated tertiary hospitals and intensive care units was noted. In addition, Telehealth legislation enacted in 2012 in California will help to increase the availability of CCS services to more rural areas.

> CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.

CCS has a plan to obtain baseline data on how many counties and clients have ‘medical homes', and how "medical home" is defined by different populations. In addition, CCS will then meet with stakeholders to gather consensus on essential elements of a medical home, and have a standardized definition of a medical home to all groups. CCS with stakeholders will develop standards for medical home. The long term objective is implementation of these medical home standards across clinical and community settings. through the 1115 Waiver program and by working with several managed care partners. CCS began the process by collecting data on how many CCS clients have medical homes, and for each client with a medical home, the person or group entity that is the identified medical home for the child.

The CCS stakeholder group identified priority objectives where successful implementation can be assessed through a survey, assessing medical homes status and family partnership in decision making. CCS continues to work with stakeholders to develop and implement a client/family satisfaction survey specific to the CCS population. CCS will seek technical assistance from HRSA to adapt the National Survey of Children with Special Health Care needs to the CCS population and to utilize it effectively.

> Improve maternal health by optimizing the health and well-being of girls and women across the life course.

MCAH has been implementing a life course approach by increasing focus on health before and after pregnancy. The Preconception Health initiative continues to maximize the value of the preconception and interconception visit by developing guidelines for care. Recent Institute of Medicine guidelines, call for funding of the preconception visit.

In addition, MCAH is focusing on empowerment of adolescents and young women by encouraging reproductive life planning (RLP). MCAH is promoting preconception peer educators at college campuses.

> Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.

Obesity, gestational diabetes and hypertension continue to be a major contributor to maternal morbidity and mortality and consequently, to infant mortality. California has a statewide Obesity Prevention Plan and the MCAH Nutrition and MCAH is linking its activities to the Plan.

> Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.

Data from the Pregnancy-Associated Mortality review (PAMR) established that cardiovascular disease is the leading cause of pregnancy-related deaths in California. In addition, about 40% of cases are possibly preventable with opportunities for quality improvement. This data informed the development of a toolkit on obstetric hemorrhage and is informing the development toolkits on preeclampsia and cardiovascular disease by CMQCC. Cardiovascular disease including cardiomyopathy appears to differentially impact African-American women while preeclampsia is diagnosed more in Hispanic women.

> Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.

The California Department of Public Health (CDPH) has accepted the Association of State and Territorial Health Officers (ASTHO) /March of Dimes (MOD) challenge to reduce preterm births by 8% by 2014. This campaign will require cross collaboration and renewed focus and effort in order to have the desired impact.

Recently the SIDS death rate has fluctuated and state experts believe this is a result of differences in investigation and coding by county coroners. There is concern that a shift in diagnosis is occurring with SIDS deaths recently being coded as "Undetermined" and "Accidental Suffocation". The goal of the SIDS Program is to continue to work with county corners and investigators on standardizing the determination of cause of death for infants who die suddenly and unexpectedly, as well as continue to support heightened awareness of safe sleeping environments.

> Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.

ACA of 2010 provided funding for creating the California Home Visiting Program (CHVP). These funds increase California's capacity to improve child and maternal health and well-being in 21 at-risk communities by helping women engage in good preventive health practices; helping parents

provide responsible and competent child care; improving the family's economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

> Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.

OFP is proposed to be moved from the Center for Family Health to the Department of Health Care Services, effective July 2012 or upon the signing of the budget. If the plan is approved, the Teen Pregnancy Prevention Programs under OFP, including the I&E Program and the California Pregnancy Responsibility and Education Program (CA PREP) will move to MCAH. Currently, MCAH is actively implementing CA PREP. MCAH's oversight of teen pregnancy prevention activities will result in strengthened capacity for adolescent reproductive health surveillance.

> Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.

All LHJs have toll-free telephone lines and monitor their use. LHJs participate in collaboratives and partnerships to improve enrollment in low-cost, no-cost insurance programs and develop systems to increase access to health and human services. Many LHJs also have home visiting or case management programs and assess and refer clients to needed services.

> Ongoing Needs Assessment Activities

Under the direction of MCAH, the Family Health Outcomes Project (FHOP) will provide a series of webinars for local MCAH Directors to prepare them for the next 5 year needs assessments. Webinar topics include information and education on the MCAH Planning Cycle.

MCAH and FHOP assessed ongoing local training and capacity needs. Findings have been used to develop capacity improvement activities.

FHOP, working collaboratively with local MCAH Directors, provided webinars on infant health, breastfeeding, healthy weight in pregnancy and program planning and evaluation and developed corresponding fact sheets that can be customized for use in local policy development activities.

Activities to monitor progress towards MCAH priority needs include statewide dissemination of slides presenting Title V National and State Performance and Outcome Measures.

MCAH revised its Scope of Work (SOW) structured around the 2011-15 MCAH Priorities. All local health jurisdictions (LHJs) have utilized the revised Scope of Work (SOW) for the 2011-12 fiscal year.

> Emerging issues related to state priorities

MCAH is working with MCMC plans to assure that all pregnant members have access to comprehensive services and to promote coordination of local MCAH programs with Medi-Cal Managed Care plans. MCAH identified the need to improve the postpartum visit in the Comprehensive Perinatal Services Program (CPSP). MCAH developed a CQI/QA Workgroup for CPSP to develop standard tools that Perinatal Services Coordinators can use to provide technical assistance to CPSP providers. The AFLP Positive Youth Development program is developing and implementing a tool to assist teens to develop a life plan using positive youth development principles.

An emerging issue is successful navigation of the tension between safe sleep and breastfeeding advocates. MCAH has and will be providing guidelines for safe sleep campaigns.

III. State Overview
A. Overview
>Geography
California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles California is home to numerous mountain ranges, valleys and deserts. [1] It is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. Depending on how urban and rural areas might be classified, as much as fifteen percent of California could be designated as rural. [2] There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, and Riverside Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions -- those with less than 600 square miles of land area -- include Santa Cruz, San Mateo, San Francisco, and Amador Counties. [1]

>Population
In 2010, an estimated 39.1 million people resided in California, an increase from 34.1 million in 2000. [3] California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020. [3] Currently, in 2010, an estimated 42% of the population is White, 37% Hispanic, 12% Asian, 6% African American, 2% multi-race, 0.6% American Indian, and 0.4% Native Hawaiian/Pacific Islander. Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the White population proportion and an increase in the Hispanic population, which will become the largest racial/ethnic group in California. The proportions of other racial and ethnic groups in California will remain relatively stable through 2020.

California's diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Filipinos and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (L.A.), Orange, and San Bernardino counties, counties with the largest percentage of Asian residents are in the San Francisco Bay Area. [3] Hispanic groups in California are predominantly Mexican (83%), followed by other Hispanic or Latino groups from Central and South America (15%). Less than 2% are Puerto Rican or Cuban. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [4] [While Southern California has the largest numbers of Hispanic residents, at 77%, Imperial County has by far the largest proportion of Hispanic residents in California. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. [5] /2012/In 2009, 28.1% or 147,766 of 526,774 births were to foreign-born Hispanic women and 23.2 % or 122,187 of 526, 774 births were to US-born Hispanic women.//2012//

/2013/> Economy
For 2012-13, the State faces a $15.7 billion budget deficit. To restore fiscal balance, more cuts to state programs and the state workforce were proposed. //2013//

>Age Distribution
In 2010, an estimated 49.4% of the child population 0-18 years of age was Hispanic, followed by White (30.5%), Asian (9.9%), and African American (5.7%). Children identified in multiple race categories were 3.6%. American Indian (AI; 0.5%) and Pacific Islanders (0.4%) made up a small proportion of the overall child population. By 2020, over 52% of children are expected to be Hispanic. The number and percent of Asian children will increase, though not as substantially as Hispanic children. The number and proportion of the White and African American children are expected to decline. Other groups are expected to remain stable. Young children 0-5 years of age

are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased from 3 million in 2000 to 3.3 million in 2010, and is projected to reach 3.8 million by 2020. The 2010 racial/ethnic distribution of the young child population was similar to children overall. As with the overall population, proportion of children ages 0-5 who are Hispanic are expected to continue to increase through 2020, while the proportion that is White are expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [3] In 2010, there were 8.1 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (41%), followed by White (37%), Asian (13%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 47%, and the percentage of White women are expected to decline to 32%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts. [6], [7] In 2010, there were an estimated 1.5 million females ages 15-19 and 875,000 females ages 15-17 in California. Hispanic females were the largest racial/ethnic group among the 15-19 year olds (47%), followed by White (33%), Asian (10%), and African American (7%). Racial/ethnic distribution was similar among females ages 15-17. /2012/ In 2011, the population of children and reproductive age women increased. Among children and reproductive age women, the Hispanic population proportion increased to 49.8% and 41.9%, respectively, the White population proportion decreased to 30.0% and 36.0%, respectively, and small or no changes were observed in other racial/ethnic groups. [3] //2012//

>Immigration
California is home to 9.9 million immigrants, the largest number and percentage of foreign born residents in the United States. [8] International immigration has accounted for 40% of California's population growth since 2000. Further, since 44.5% of California births are to women born outside the U.S., [9] the well-being of this population has a strong influence on overall MCAH status in California. Most of California's immigrants are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000) and China (659,000). [9] Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents: 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor. [10] California has the largest number and proportion of undocumented immigrants of any state. [11]] Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990.[11] In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. [10]

>Languages Spoken
Limited English proficiency (being able to speak English less than ‘very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age, 14.3 million speak a language other than English at home and 6.7 million have limited English proficiency. [8] California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner who is not proficient in English. These 1.5 million students speak 56 different languages, but over 1.2 million of ELL students are Spanish speakers. Other common languages are Vietnamese, Filipino, Cantonese, and Hmong. ELL students reside in every county in California, and in 14 counties in California's Southern, Central Valley, and San Francisco Bay areas, ELL students make up over 25% of the student population. [13]

>Education
In California, one in five individuals over the age of 25 has not completed high school and nearly 10% has not completed 9th grade. Further, measures of educational attainment show that while graduation rates have declined only slightly from 69.6% in 2000 to 68.5% in 2008, drop-out rates have risen sharply from 10.8% in 2000 to18.9% in 2008. [14] Educational attainment varies greatly by race/ethnicity and gender. The 2007-08 dropout rate was higher than the state average for African Americans (32.9%), AI /Alaska Natives (AN; 24.1%), Hispanics (23.8%), and Pacific Islanders (21.3%), and was lower than the state average for Whites (11.7%), Filipinos (8.6%) and Asians (7.9%). [15] California's high school graduation rate for African Americans (59.4%) and Hispanics (60.3%) was substantially lower than for Whites (79.7%) and Asians (91.7%). The graduation rate for females (75.8%) is higher than for males (67.3%) overall, and for each racial/ethnic group. [16] /2012/ In 2009, the drop-out rate increased across racial/ethnic groups. [17] In 2009, the graduation rate increased to 70%.[18] //2012//

>Income
According to the most recent census data, over 4.6 million Californians, 13% of the population, have incomes at or below 100 percent of the federal poverty level (FPL). The 100 percent FPL in 2008 was $21, 200 for a family of four. African Americans, Hispanics, and AI have the highest rates of poverty in California. [19] Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. [20] Projections of child poverty rates through 2012 anticipate that child poverty in California will increase as a result of the recession, peaking at 27% in 2010 before declining slightly to 24% in 2012. In L.A. County, home to 25% of California's children, one in three children is projected to be in poverty in 2010. California child poverty varies tremendously by region. Counties with the highest child poverty rates are in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates of child poverty (below 10%) are in the San Francisco Bay Area, Wine Country, and the Lake Tahoe/mountain recreational area. [20] Only examining the federal poverty level obscures the struggles faced by many families in California because of the high cost of living in this state. An alternate measure of poverty is the self-sufficiency standard, a measure of the income required to meet basic needs (housing, child care, transportation, health care, food, applicable taxes and tax credits and other miscellaneous expenses) that accounts for family composition and regional differences in the cost of living. While 1.4 million (11.3%) of California households are below the FPL, an additional 1.5 million households in California lack adequate income to meet basic needs. [21]] [22]Income insufficiency is highest among households with children. Among households with children, 36% of married couple households, 47% of single father households, and 64% of single mother households have insufficient income to meet basic needs. Households headed by single mothers in some racial/ethnic groups have even higher rates of income insufficiency. Nearly 8 out of 10 Hispanic single mother households and fully 7 out of 10 African American single mother households experience income insufficiency. The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. [22]It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate. [23]] /2012/ Poverty among children under age 18 rose to 19.9% in 2009. Another poverty indicator, the percent of public school students eligible for free or reduced price school lunch, increased from 51.0% in 2006 to 55.9% in 2010. [24] While employment grew in 2010, the unemployment rate also increased to 12.4%, the third highest rate in the U.S. [25] Economic recovery has been uneven with some LHJs experiencing continued job losses in 2010. The construction and retail industries experienced continued employment decline in 2010 by more than 10%. [26] //2012//

>Housing
California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [28] Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing

or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections. [28] It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, public parks, grocery stores and parks. In 2010, the fair market rent in California ranged from $672 in Tulare County to $1,760 in San Francisco Bay Area counties. [29] Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent. [30] The current foreclosure crisis has greatly impacted California home-owner families. In 2008 and 2009 combined, there were over 425,000 residential foreclosures in California. [31] Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity. Inability to access affordable housing leads to homelessness for some families. More than 292,000 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States, with only Texas and Louisiana having worse rates among children. [32] Homelessness in children has been linked to behavioral health problems, [28] and negatively impacts educational progress. [32]] /2012/ Concerns have increased about the effect of foreclosure on renters and community members continuing to live in neighborhoods impacted by high rates of foreclosure. In 2010, there were about 170,000 foreclosures. [31] //2012//

/2013/ In December 2011, California had the second highest rate of foreclosures in the country. [33] //2013//

>Public Health System
CDPH is the lead state entity in California providing core public health functions and essential services. The Department has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The MCAH Program, the lead entity that manages the Title V Block Grant is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, family planning services, prenatal and newborn screening (NBS)and programs directed at addressing teen pregnancy, maternal and child health and genetic disease detection. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion (CCDPHP) which provide surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing food borne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and licenses personnel; and the Center for Infectious Diseases which provide surveillance, health education, prevention and control of communicable diseases. To facilitate health planning and coordination and delivery of public health services in the community, California is divided into 61 LHJs, including 58 counties and three incorporated cities. These cities are Berkeley, Long Beach, and Pasadena. In addition to providing the basic framework to protect the health of the community through prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture, tremendous diversity also exists in how LHJs organize, fund and administer health programs. MCAH allocates Title V funds to LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work. LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include the Adolescent Family Life Program (AFLP), the Black Infant Health Program (BIH), the California Perinatal Services Program (CPSP), the Sudden Infant Death Syndrome (SIDS) education and

support services, and Fetal and Infant Mortality Review (FIMR). /2012/ CCS addresses the health service needs of CSHCN in the state. These services include diagnostics and treatment, case management, and physical/occupational therapy for children under age 21 with CCS-eligible medical conditions. Larger counties operate their own CCS programs and smaller counties share the operation of their programs with the state CCS regional offices: Sacramento, San Francisco and L.A..//2012//

/2013/ The Office of Family Planning (OFP) was moved from CDPH to the Department of Health Care Services (DHCS) effective July 2012 The Teen Pregnancy Prevention Programs under OFP, including the I&E Program and the California Personal Responsibility Education Program (CA PREP) will move to MCAH. Currently, MCAH is actively implementing CA PREP. Additionally, the Governor's budget proposes the development of the Office of Health Equity under CDPH, which will consolidate multiple organizational entities in multiple Human and Health Service agencies.

The Governor established the Get Healthy California Task Force in May 2012 to improve the health of Californians.

> Access to Health Care
In California, 19 percent of the population did not have health insurance in 2009/10, and highest among Hispanics [36]

> Healthcare Reform
The Patient Protection and Affordable Care Act of 2010 (ACA) created a new mechanism for purchasing health insurance coverage called a Health Benefit Exchange (HBEX). California was the first state to pass legislation to create a HBEX, a quasi-governmental body that follows the "active purchaser" model of benefits exchanges. [40] //2013//

Major State Initiatives
The process used by MCAH to prioritize and address current and emerging issues impacting the health of the MCAH population through its major initiatives is multifaceted. This process includes monitoring the MCAH population health status, consultation with our stakeholders, collaboration with local MCAH directors, partnering with programs within CDPH and with staff from other departments such as the California Department of Education (CDE), the California Department of Social Services (DSS), DHCS and the Alcohol and Drug Programs (ADP); and, with a variety of public health educators, clinicians and organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCAH priorities and priority needs identified through the needs assessment process. The process includes consideration of public input, alignment with CDPH's strategic plan and priorities, availability of resources and the political will to address these factors. /2012/ A more in-depth discussion of the major state initiatives is included as an attachment to this section.//2012// Given this multifaceted approach, California's Title V major state initiatives include the following:

>1115 Waiver, Promoting Organized Systems of Care for Children with Special Health Care Needs (CSCHN)
California's Medicaid Section 1115 waiver for hospital financing and uninsured care expired on August 2010 and provides an opportunity to transform the delivery of health care to children enrolled in CCS in a more efficient manner that improves coordination and quality of care through integration of delivery systems, uses and supports medical homes and provides incentives for specialty and non-specialty care with a new waiver application.

Pursuant to (Assembly Bill (AB) x4 6, August 2009), DHCS submitted a new and comprehensive Section 1115 Medicaid waiver. This legislation sought to advance two policy objectives in restructuring the organization and delivery of services to be more responsive to the health care needs of enrollees to improve their health care outcomes and slowing the long-term rate of Medi-Cal program expenditures.

A Stakeholder Advisory Committee consists of individuals representing the populations for whom the delivery of care would be restructured through the waiver design. Reporting to the Stakeholder Advisory Group are technical workgroups (TWG) constructed to discuss each of the populations and make recommendations to DHCS on what could be included in the 1115 Waiver that would improve the delivery of care for CSHCN. The CCS TWG workgroup has assisted in specifically recommending several delivery models to pilot test in order to determine if any one of them can used to more effectively provide care for CCS clients. The CCS TWG has advised retention of the successful parts of the CCS program including quality standards and the network of providers.

Members of the CCS TWG represent families, provider organizations (American Academy of Pediatrics[AAP-CA], Children's Specialty Care Coalition, California Association of Medical Product Suppliers, and California Children's Hospital Association); County CCS programs and County Health Administrators; foundations and MCMC health plans. The activities of the CCS TWG have been supported by the Lucile Packard Foundation for Children's Health. Specific information on the CCS TWG can be found at:
http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx.

/2012/The "Bridge to Reform" Section 1115 Waiver was approved in November 2010. In April 2011 the Request for Proposal to implement the CCS portion of the Waiver was released seeking applications from qualified entities to develop and administer Demonstration Projects for a group of CCS clients. //2012// ***/2013/Five projects were selected with 4 different models of care through which CCS children will have all their health care needs met through a single coordinated health system. Projects have phased-in start dates from June 2012 to 2013 and an evaluation program is under development.//2013//***

>Child Health Insurance Coverage
State legislation AB 1422, along with funding from the First Five Commission and program savings enacted by the Managed Risk Medical Insurance Board (MRMIB) will allow the Healthy Families Program, (HF), California's low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

From July 2003 through December 2009, over 4 million children receiving assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits. The number of families utilizing the CHDP via this process appears to gradually increase due to the number of families losing private health insurance due to the economy. /2012/ From July 2003 through 2010, over 4.4 million children were pre-enrolled.//2012// ***//2013//From July 2003 through 2011, over 5.8 million children were pre-enrolled.***

> Obesity
See National Performance Measure 14 and State Performance Measure 6.//2013//

>Breastfeeding
Due to state budget cuts in August 2009, funds were reduced for the Birth and Beyond California (BBC) a hospital-based breastfeeding continuous quality improvement (QI) project which promotes model hospital policies to improve in-hospital exclusive breastfeeding rates. Funding continues for RPPC in L.A. to develop a report on BBC pilot project findings and provide TA for all other RPPC regions for 2 years. To date, 20 hospitals participated and 2 RPPC regions obtained other funds to continue the BBC work. BBC curricula and tools will be posted on the MCAH breastfeeding website.

/2012/ In addition to the original 23 hospitals that participated in the BBC project, 13 more hospitals have successfully completed this program without the support of CDPH funding. BBC generated national interest and was highlighted at the first California Hospital Breastfeeding Summit held in January 2011. //2012//

/2013/MCAH released the "BBC: A Hospital Breastfeeding Quality Improvement and Staff Training Demonstration Project Report". Curricula, trainer notes, evaluation tools, and other materials for hospitals are posted at http://cdph.ca.gov/BBCProject.//2013//

MCAH is in the process of releasing 2008 in-hospital exclusive breastfeeding data and be made available online with links to resources to help hospitals improve their exclusive breastfeeding rate.

In December 2009, MCAH and the Women, Infants and Children (WIC) Supplemental Nutrition Program, in collaboration with the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable met for the second time in June 2010 and has drafted a strategic plan that will be used by the CDPH Nutrition, Physical Activity and Obesity Prevention Program (PAOPP) grant funded by the Centers for Disease Control and Prevention (CDC). MCAH is represented in the US Breastfeeding Committee and be involved in its national promotion of workplace lactation support. MCAH has been advocating for a new CDPH lactation policy and piloting a bring-your-infant to work lactation supportive policy.

CCS is partnering with CPQCC in a breast milk nutrition quality improvement collaborative for 2010 involving 11 community and regional Neonatal Intensive Care Units (NICUs) with a goal of collaboratively improving by 25% any breast milk at discharge for <1500 gm. infants. The baseline period is 10/1/08 through 9/30/09 and the intervention timeframe is 10/1/09 through 9/30/10. Each NICU has its own goal statement and is also collecting data on process and balancing metrics. In addition to monthly calls and exchanges via e-mail, there are three face-to-face learning sessions in 2010. /2012/This Collaborative ended October 2011. The goal of improving by 25% any breastfeeding at discharge for <1500gm infants was met.//2012//

/2013/ WIC and MCAH finalized a web-based hospital breastfeeding policy curriculum for hospital administrators. In 2011, the Infant Feeding Act was passed requiring that all maternity hospitals have an infant feeding policy that supports breastfeeding by 2014. //2013//

>Comprehensive Black Infant Health (BIH) Program assessment
MCAH places a high priority on addressing the persistent poor birth outcomes that disproportionately impact the African American community. MCAH has focused efforts to address social disparities to close the gap--BIH is central in these efforts.

The report recommended the development and implementation of a single core model for all local BIH program sites to enhance the impact on African American infant and maternal health. MCAH convened groups of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center on Social Disparities in Health staff to develop various aspects of the revised model and comprehensive evaluation plan. The revised model integrates the most current scientific findings, ***/2013/lessons learned from our previous model, staff and partner expertise//2013//*** and state and national best practices. The revised model is strength-based, ensures linkages to prenatal care and empowers women to make better health choices for themselves and their families and improve their ability to manage stress related to the social, cultural, and economic issues that are known to influence health, and encourages broader community engagement to address the problem of poor birth outcomes. Services are provided in a culturally competent manner.

The program starts an assessment of clients' needs and strengths. There is primarily case management based on each client's needs. Central to this model is the 20 session group intervention (10 prenatal and 10 postpartum) that encourages and supports behaviors to help African American women become strong individuals and effective parents. The evaluation and data collection process has been revised to assess the program's effectiveness and has program

standards and quality assurance measures to ensure the revised model's fidelity. In June 2010, a panel of national experts that was convened endorsed the concept; felt the model was scientifically supported and made recommendations for refinement.

Training on the new model and pilot implementation was conducted at approximately half of the BIH sites in summer of 2010.

/2012/ In November 2010, eight of the 15 BIH sites implemented the revised model. Initial qualitative reports indicate that clients are well engaged and find the group intervention positive and empowering. An early assessment finds that sites have found two major issues: (1) state and local administrative and logistical challenges delayed implementation and transition between the former model and revised model, resulting in loss of recruitment sources, and (2) local sites have not changed their recruitment messages to reflect the revised model. MCAH, working collaboratively with UCSF Center for Social Disparities in Health, and local sites are addressing client recruitment. BIH sites will be required to complete a client recruitment plan. MCAH will be transitioning the remaining sites through TA and training, to begin implementation in November 2011.//2012//

/2013/ The revised model was implemented in November 2011. In March 2012, MCAH published the report entitled: Black Infant Health Program Pilot Implementation (Phase I) Preliminary Assessment Report. In 2012, MCAH will conduct site profiles of each LHJ and launch an upgraded management information system.//2013//

>Preconception Health
While the main goal of preconception care is to provide health promotion, and screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies, Implicit in its Preconception Health and Health Care Initiative (PHHI) MCAH employs a life course perspective that promotes health for women and girls across the lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes. MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice, develop policy strategies to support preconception care and promote preconception health messaging for women of reproductive age.

/2012/ The Preconception Health Council of California//2012// (PHCC), established in 2006 through a partnership between MCAH and MOD, remains at the center of preconception health activities in the state. In May 2009, the PHCC launched a comprehensive preconception health website--Every Woman California. The website features information about health considerations for women of childbearing age --including low-literacy PDFs on 21 preconception health topics -- as well as resources, tools and best practices for providers. The website has a partner registration feature to encourage networking and resource sharing among those interested in preconception health and health care and features interactive event calendars and discussion forums: http://www.everywomancalifornia.org. /2012/ ***/2013/ It was updated in 2012 and features reproductive life planning (RLP) and new preconception health clinical resources and statewide initiatives. //2013//***

MCAH worked to incorporate preconception health messaging by including interconception curriculum content in BIH and the trainer module for California Diabetes and Pregnancy Program (CDAPP).//2012//

Other preconception health activities include a folic acid awareness campaign implemented in early 2009 designed to address Latinas and women of lower education attainment. It, featured Spanish language radio Public Service Announcements (PSAs); outreach to the community through health promoter training; and vitamin distribution and education through local public health programs. The campaign resulted in a 1200% increase in calls to referral line and 45,000 bottles of vitamins distributed.

MCAH received the First Time Motherhood grant funds from Health Resources and Services Administration (HRSA)/MCHB to implement a preconception health social marketing campaign. /2012/ Data indicated that the lowest prevalence of daily folic acid use was among Latinas, and the lowest prevalence of healthy weight and smoking abstinence were among African Americans.//2012// The project will test "preconception health" and RLP messages in a life course context and message delivery mechanisms, including web- and mobile-based strategies, with different populations, especially African-American women, Latinas and youth of color. The campaign will also address broader societal influences on health. MCAH will be working on this campaign through early 2011. ***/2013/ PHHI collaborated with AFLP PYD to develop the RLP guiding framework and tool for the client-centered goal setting teen pregnancy prevention program. //2013//***

MCAH staff continues to participate in a number of national preconception health-related workgroups including the national preconception health indicators workgroup***/2013/, the national expert panel on life course metrics //2013//*** and the CDC's preconception health consumer workgroup.

PHCC is the coordinating hub for preconception health activities across the state such as the Interconception Care Project of California (ICPC), an American Congress of Obstetrics and Gynecologists (ACOG), District IX project funded by MOD that is charged with developing postpartum care visit guidelines for obstetric providers. The project aims to provide physicians with tools to address issues at the post-partum visit that could affect a subsequent pregnancy and counsel the patient about /2012/ways to improve their health status and //2012// plans for future children. ***/2013/ ICPC guidelines were completed and include English and Spanish provider algorithms and patient handouts on 21 common postpartum conditions. Providers were informed of its availability and guideline trainings were offered. //2013//***

MCAH LHJs have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care produced a curriculum for public health providers; published a data brief on preconception health in LA County; established a website; held a second preconception health summit for providers in the county; and developed an evaluation framework for the collaborative. It also oversees local preconception health projects that have had promising results such as the California Family Health Council's (CFHC) effort to develop and introduce a pre/interconception care curriculum into nearly 80 Title X clinics and the Public Health Foundation Enterprises WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout L.A. and Orange County. ***/2013/PHHI developed preconception health scope of work objectives and provided technical assistance to MCAH LHJs. State and local MCAH are partnering to implement the federal Office of Minority Health Peer Preconception Health Program in community colleges and universities //2013//***

>High-Risk Infants

The High Risk Infant Follow-up Program (HRIF) screens babies who might develop CCS-eligible conditions after discharge from a NICU and assure access to quality specialty diagnostic care services. All CCS-approved NICUs are required to have a HRIF Program or a written agreement for services by another CCS-approved HRIF Program.

In 2006, CCS redesigned HRIF and started the Quality of Care Initiative (QCI) with CPQCC. The QCI developed a web based reporting system to collect HRIF data to be used in quality improvement activities. As of March 2010, 60 of the 74 CCS-approved HRIF Programs are reporting on-line, with a reporting of over 2,000 HRIF Program referrals and 1500 HRIF Program visits. /2012/As of March 2011, 62 of the 65 CCS-approved HRIF Programs are reporting on-line, with over 10,860 HRIF Program Referrals/Registrations and 7,181 HRIF Program Standard Core Visits.//2012// ***/2013/As of February 2012, 65 of 66 CCS-approved HRIF programs are reporting online, with 19,055 HRIF Program Referrals/Registrations and 17,079 HRIF***

Program Standard Core Visits. The HRIF Executive Committee established a quality improvement (QI) workgroup in February 2012. //2013//

>Neonatal Quality Improvement Initiative
CMS and the California Children's Hospital Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease Central Line Associated Blood Stream Infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for QI. Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning Jan. 2008. After the grant extension ended in June 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 they are adding bloodstream infection (BSI) prevention. For 2009 the CLABSI rate for the 14 NICUs was 2.05 for all weights, and competing priorities have been the greatest barrier to infection prevention. /2012/For 2010, the CLABSI rate for all weights had decreased to 0.97, which is a 77% decrease since the inception of the Collaborative in 2006. The Collaborative is continuing in 2011 and will be inviting more Regional NICUs to join.//2012//

/2013/ By mid-2011, CLABSI rate decreased another 70% from 2009; for all birth weights combined it has declined to 0.65 infections / 1000 central line-days. Participating NICUs are implementing practice policies. To comply with Section 2701 of the ACA, elements of the NICU CLABSI collaborative will be brought to all CCS approved NICUs and PICUs beginning July 2012. //2013//.

>Pediatric Critical Care
CMS has structured a system of 21 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts PICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. /2012/There are 22 PICUs; Pediatric Risk of Mortality III data are collected.//2012//

CMS and the University of California, Davis conducted a survey of PICU medical directors to assess the infrastructure for Pediatric Critical Care quality care and the need for statewide benchmarking standards to direct QI efforts. CMS will focus on collaboration with PICU leadership in developing a statewide data collection and reporting system for QI purposes. /2012/Work is progressing on the comprehensive severity-adjusted PICU database and finalizing standards for Community Level PICUs.//2012//

/2013/ In February 2012, there were 23 CCS-approved PICUs. Annual PICU reports are stratified by PRISM III scores or data is through the Virtual PICU Performance System (VPS) which exports data into the Pediatric Intensive Care Unit Evaluation (PICUEs)-PRISM III program. An Institutional and Comparative Report is submitted by PICUs. A second level PICU, designated as "Community PICU" has been. A PICU Regional Cooperative Agreement (RCA is under development. //2013//

>Pediatric Palliative Care
CMS submitted a 1915(c) waiver to the Centers for Medicare and Medicaid Services which was approved December 2008. Many stakeholders across California and in other states participated in the development of the waiver program. The program, which began to enroll children in January 2010, allows Medi-Cal clients to receive hospice-like services at home while concurrently receiving curative treatments. The program partners with hospice and home health agencies to provide a range of services to improve the quality of life for eligible children and their families including care coordination, family training, expressive therapies, respite care and bereavement counseling for caregivers. The initial three year program started in five counties: Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego, and will expand to 13 counties by the third

year. /2012/A request for amendment was submitted to CMS and approved to add the service: 'pain and symptom management' (by hospice providers) in October 2010. Year 2 has started in Marin, Orange, SF, and Sonoma counties and is projected to expand to Fresno and LA counties this fall; these (including the first 5) are the targeted 11 counties.//2012//

/2013/The waiver was originally approved April 2009 through March 2012 for 11 of the original 13 counties participating. Medical eligibility criteria were expanded in August 2011 to include any child with a life-threatening or life-limiting CCS-eligible condition with anticipation of 30 inpatient days in the next year, who would benefit from the supportive palliative services offered by PFC. The five year waiver renewal application has been submitted. //2013//

>Maternal Health
Maternal mortality doubled in California since 1998 to 16.9 deaths per 100,000 live births in 2006, well above the Healthy People 2010 benchmark. African-American women were roughly four times more likely to die from pregnancy-related causes with 46.1 deaths per 100,000 live births compared to 12.9 for Hispanic women, 12.4 for White women and 9.3 for Asian women. /2012/ In 2008, maternal mortality dropped slightly. However, the disparity ratio for African --American mothers continued to rise.//2012// Subsequently, MCAH has supported diverse efforts to identify and address factors that appear to be contributing to increasing rates of maternal morbidity and mortality in California under the "Safe Motherhood" initiative.

First, MCAH gathers and manages statewide and local data needed to analyze factors related to poor birth outcomes and perinatal morbidity and mortality. MCAH conducts the PAMR which is the first statewide fatality review of maternal deaths. Pregnancy-related deaths from 2002 and 2003 have been reviewed and a report on findings is in development. /2012/ The California Pregnancy-Associated Mortality Review: Report on cases reviewed from 2002-2003 was released in April 2011 which describes the methods, the key findings and recommendations from the Committee. Findings have informed MCAH strategies for addressing the rise in maternal mortality. //2012// The Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California. /2012/ MQI has found significant change in maternal morbidity with increased rates of diabetes, maternal hypertension and asthma.//2012//

Secondly, MCAH promotes creation of regionalized collaborative networks of care and ensure that patients access care appropriate to their level of risk. RPPC is a statewide regional network that provides consultation to all delivery hospitals and uses current statewide and hospital-specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatalogists for high-risk mothers and their infants. /2012/ RPPC work with obstetric hospitals to incorporate two obstetric care toolkits; "Improving the Health Response to Obstetrical Hemorrhage" and "Elimination of Non-Medically Indicated Deliveries prior to 39 Weeks Gestation."//2012// The California Perinatal Transport System (CPeTS) facilitates transport of mothers with high-risk conditions and critically ill infants to regional intensive care units and collects transport data for regional planning and outcome analysis. MCAH also provide support for local programs to improve maternal health through maternity care improvement projects (Local Assistance for Maternal Health). Currently, San Bernardino County is providing leadership to reduce non-medically indicated labor induction with anticipated health benefits to mother and infant. L.A. County is leading a collaborative effort to improve hospital response to obstetrical hemorrhage, a leading cause of maternal morbidity and mortality. /2012/ The projects in San Bernardino and L.A. county will close at the end of June 2011 and two more counties have been selected to lead county wide efforts in a maternity care quality improvement project.//2012// ***/2013/Several LHJs are promoting preconception health.//2013//***

Thirdly, MCAH has developed a Maternal Health Framework (MHF) to guide program development, including improvements for current programs and opportunities to create new

programs. The MHF considers social and ecological contributing factors to maternal health in 3 phases of the life course: prior to, during and following pregnancy to restore a mother to health should a health complication arise during pregnancy./2012/ The MHF is being shared with all MCAH LHJs and external stakeholders as an example of an application of life course theory to real world public health policy and program planning. //2012//

For Phase I, the Preconception Health programs (described elsewhere) are focusing on maximizing health of women and girls of reproductive age before they get pregnant. Some programs target pregnant women with the goal of maximizing health during pregnancy.

For Phase II, the BIH program addresses health disparities for African-American mothers and children by facilitating access to prenatal care and providing health education and social support services to mothers. CPSP provides enhanced prenatal services to meet nutrition, psychosocial and health education needs of clients. AFLP provides case management and education to pregnant and parenting adolescents to promote healthy pregnancy outcomes, effective parenting and socioeconomic independence. OFP provides comprehensive education, family planning services, contraception and reproductive health services with the goal of reducing unintended pregnancies and optimizing maternal health prior to pregnancy.

Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. CDAPP recruits, educates and provides consultation and technical assistance to providers who deliver comprehensive health services for high-risk pregnant women with pre-existing diabetes or women who develop diabetes while pregnant. CMQCC has developed two QI toolkits: one to reduce morbidity of obstetrical hemorrhage, a common complication of pregnancy and one to reduce elective inductions of labor prior to 39 weeks gestation which appears to be associated with higher rates of cesarean delivery. ***/2013/ The toolkit to reduce elective inductions prior to 39 weeks gestation was licensed to the MOD for national dissemination. The obstetric hemorrhage toolkit will be translated into Spanish and distributed throughout Mexico based on an agreement with a Mexican national perinatal treatment center and the California Office of Binational Border Health. A third toolkit to improve the quality of care for preeclampsia is now in development. //2013//***

WIC contributes to optimizing health outcomes throughout all three phases by linking families to local community and public health services and by providing lactation support, nutrition education and nutritious food to low income pregnant women, new mothers and children.

>Data and Surveillance
In 2010, MCAH began collaborating with WIC on public health research projects. The goal of the first project is to create data linkages between WIC program data, the Birth Statistical Master File and MCAH program data in order to identify areas in California where there is a need for WIC services and opportunities to better target WIC services to MCAH populations, and to evaluate outcomes associated with the receipt of WIC services. Geographic information systems (GIS) and 21 hotspot maps will be used to examine results at local levels. /2012/Analyses were completed for linked 2008 data during the past year. Choropleth maps and hot-spot analyses were completed for specific counties and used by WIC to target resources in a funding announcement. Choropleth maps were then generated and disseminated to other WIC program areas for local planning and outreach. . Data for 2009 were linked and will get analyzed in 2011 for similar resource allocation and planning purposes. MCAH also provided training and TA to State WIC staff as well as local WIC providers and agencies on how to interpret and use chloropleth maps;. //2012// ***/2013/ In 2012, WIC program data were linked to the 2010 birth file. MCAH has begun to develop maps using the 2010 data, and a detailed report on WIC participation around the time of pregnancy. //2013//***

Second, California's Maternal and Infant Health Assessment (MIHA) Survey was expanded in 2010. /2012/ MIHA achieved a high response rate with the 2010 expanded sample, assuring

adequate sample size for the proposed state and select county-level analyses of income-eligible women who are not enrolled in WIC. In 2010, women were asked their reasons for not being on WIC. These preliminary results were shared with WIC. The final 2010 data set will be available in July 2011 and MCAH and WIC are working to identify priority analyses and applied uses of these data. //2012// ***/2013/ County-level data tables and charts were published. //2013//***

Over the past year, MCAH collaborated with CDC to develop seven proposed Healthy People 2020 measures, which will combine data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and MIHA. The combined estimates will allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States.

/2012/ Six PRAMS-MIHA Healthy People 2020 (HP 2020)measures have been accepted as part of the Maternal, Infant, and Child Health topic area to provide baseline data for each HP 2020 objective. Additionally, MCAH collaborated with researchers at UCSF and CDC to submit an abstract to the 3rd National Preconception Health Conference in June 2011, highlighting the new HP 2020 objectives related to preconception/ interconception health, current baseline estimates and targets for 2020, and ways that states can use PRAMS-MIHA data to monitor and inform efforts to achieve HP 2020 targets. //2012//

/2012/ Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California annually. Joint meetings target area hospitals with missing data and RPPC assist with presentations to birth clerks who collect birth data to better understand the items on the birth certificate, definitions of medical terms listed, and how the data helps to improve care for women and their infants. Local and state birth registrars, county MCAH Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff are brought together, and hospitals are recognized for improvement and high achievement. In 2010, more than 530 participants attended a workshop. ***/2013/ 2012 is the 8th year for these workshops to improve birth data quality.//2013//***

MCAH is making a concerted effort to increase surveillance capacity with GIS through use of enhanced address standardization and geocoding techniques; complex spatial analyses; automated map development with use of the Python coding language; and map building and sharing through interactive online maps. Thematic maps, spider diagrams, and statistically based hot-spot analyses of data from multiple sources (MCAH, WIC, Vital Statistics, the American Community Survey and others) have been used to locate regions at the state, county and local level in need of enhanced public health services. Hot-spot analyses were conducted to locate clusters of women in need of WIC services, or could benefit from home visiting program services.

Specialized spider diagram maps were developed to analyze geospatial associations between place of residence of mothers with very low birth weight (VLBW) infants, their delivery hospital and nearest NICU have illustrated the role that distance can play in access to appropriate care for VLBW infants.

MCAH LHJ data books, used for local surveillance and needs assessment activities, are being revised by the Family Health Outcomes Project (FHOP) to enhance local surveillance. New indicators will be added to align with the new state priorities, State Performance Measures, and social determinants of health. Data books will be updated each year to support regular community-level monitoring, as is required by the new LHJ scopes of work.

MCAH disseminates breastfeeding initiation rates annually to all maternity hospitals and provides them with TA to implement evidence-based policies and practices that support breastfeeding. The California WIC Association (CWA) has used these data to publish an annual report that ranks hospitals based on breastfeeding rates generating media attention. California breastfeeding data are available at: http://cdph.ca.gov/breastfeedingdata.

/2013/ MCAH continues to post hospital breastfeeding initiation data. These data were used by the CWA to publish their reports.

CCS performance measure data is reported annually by counties. For the Medical Home performance measure, 83% of CCS clients have medical homes, based on county reports of clients with Medical home, which range from 42% to 99%.

>California's Primary and Secondary Teen Pregnancy Prevention Initiatives
Incorporation of teen pregnancy prevention programs into MCAH affords an opportunity for coordinated service delivery across primary and secondary teen pregnancy prevention efforts.//2013//.

>AFLP PYD
In September 2010, MCAH received notification of a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. MCAH received $2 million per year for 3 years, beginning 2010- 2011. MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its Adolescent Family Life Program and the California School-age Families Education Program (Cal-SAFE) . The intent is to maximize use of limited resources through the AFLP provision of case management and support services and the Cal-SAFE provision of child and developmental services to support AFLP client school completion. ***/2013/ MCAH awarded 11 local sites for piloting the new positive youth development case management intervention with integrated life planning to promote reproductive life planning and build youth resiliency.***

>California Personal Responsibility Education Program (CA PREP)
PREP educates adolescents on abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), through evidence-based program models and adulthood preparation subjects.

>Information and Education (I&E)
I&E provides adolescents with pregnancy and STI prevention information and linkages to health care. Funded through state general funds and matching Title XIX funds, the most recent RFA for this program was released in, 2010, and made funding available from Summer 2012 to Fall 2016.//2013//

> Home Visiting Program
The Maternal, Infant and Early Childhood Home Visiting Program was established on March 23, 2010 by the ACA of 2010, which amended Title V of the Social Security Act by adding Section 511. MCAH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and ACF, MCAH began working in partnership with DSS, ADP, the California Head Start State Collaboration Office (CHSSCO) of CDE, and local stakeholders from each of California's 61 LHJs in order to develop California's Home Visiting Program application (submission, July 9, 2010), Needs Assessment (submission September 20, 2010), and Updated State Plan (submission June 9, 2011). ***/2013/MCAH was awarded the Home Visiting Expansion Grant to increase the number of communities served. This effort targets particularly high risk and difficult to enroll populations and evaluates individual, program and community factors affecting enrollment and retention. MCAH anticipates implementation of home visiting programs by mid-year 2012.***

Two evidence-based models, Nurse-Family Partnership (NFP) and Healthy Families America, were selected to meet the needs of the 21 funded communities identified as "at-risk" through a formal Needs Assessment, a geospatial hot-spot analysis using quantitative data, and qualitative information from local MCAH Directors.

>Health Communications and Public Health Successes
MCAH continues its strong partnership with key partners including local MCAH programs. MCAH helped develop news releases on teen births and infant mortality. MCAH developed fact sheets on multiple MCAH-related health issues.

>Strategic Map
CDPH developed, and will implement the Strategic Map, a graphic representation of CDPH's strategy. MCAH provided input in its development and will participate in CDPH strategic priorities and objectives.//2013//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

California has a statewide system of programs and services that provides comprehensive, community-based, coordinated, culturally competent, family-centered care. For example, Special Care Centers (SCCs) and hospitals that apply to become CCS-approved must meet specific criteria for family-centered care (FCC). FCC is assessed by the CMS Branch as part of the ongoing review process of CCS-approved SCCs and hospitals. Local CCS programs facilitate FCC by assisting families to access authorized services, such as pediatric specialty and subspecialty care, and by providing reimbursement for travel expenses, meals, and motel rooms during extended hospital stays.

MCAH and CMS programs provide direct services, enabling services, population-based services and/or infrastructure-building services. A table is attached as a guide to identify the lead agencies with which these programs are affiliated, the primary population these programs target; pregnant women; mothers and infants; children, adolescents, and CSCHN) and the availability of the program at the local or community level. These programs were created or permitted by statute and include the following:

>Adolescent Family Life Program (AFLP)
AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society. It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and Temporary Assistance for Needy Families (TANF) or CalWorks as it is known in California . AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 programs throughout the State. In many counties, AFLP is the only case management program available for pregnant and parenting teens. /2012/ The caseload for 2010 was 8,902 clients in 37 programs /2012// ***/2013/ MCAH awarded 11 local agencies to increase program capacity and professional development in the area of positive youth development. //2013//***

>Black Infant Health (BIH)
BIH which has the goal of reducing African American infant mortality in California uses case management and group interventions to support African American women in their pregnancies and improve birth outcomes. The BIH program is currently serving approximately 3000 women in 16 programs in the State. /2012/BIH revised services to include a client-centered, strength-based group intervention with case management. //2012//

>California Birth Defects Monitoring Program (CBDMP)
CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. The 2006 birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000

pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 linkage will be completed soon. ***/2013/ Birth year information is linked to vital statistics data for 8 counties. The CBDMP Registry has data for more than 140,000 babies with birth defects since 1983. //2013//***

>California Children's Services (CCS) Program
CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

The program authorizes medical and dental services for CCS-eligible conditions, establishes standards for providers, hospitals, and SCCs for the delivery of care, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions. Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share administrative and case management activities with CMS Branch Regional Offices. Social Security Income (SSI) beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. /2012/The CCS caseload for FFY 2009 is 179,306 of which 76.1% are in Medi-Cal; 14.3% in HF, and 9.6% in state only CCS.//2012// ***/2013/ There were 246,301 clients in the CCS Program in SFY 10-11, based on the CMS Net system. //2013//***

CCS has a regional affiliation system with 114 CCS-approved NICUs. NICUs providing basic level intensive care services are required to enter in to a Regional Cooperation Agreement (RCA) with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS approves the designated level of patient care (Intermediate, Community and Regional) provided in each NICU, and verifies that the RCA is in place. Starting with 2004 data, all CCS NICUs are required to submit their CCS data through CPQCC.

>California Diabetes and Pregnancy Program (CDAPP)
CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Regional teams of dietitians, nurses, behavioral specialists and diabetic educators provide training and technical assistance to promote quality care provided by local Sweet Success providers and to recruit and train new Sweet Success providers in areas of need. ***/2013/ CDAPP funding for regional services was eliminated; however, a resource and training Center will be maintained.//2013//***

>California Early Childhood Comprehensive Systems (ECCS)
ECCS promotes universal and standardized social, emotional and developmental screening. ECCS collaborative efforts provide CHDP with guidance on validated and standardized developmental/social-emotional health screening tools for earlier identification of children with developmental delays. The revised guidelines were an important collaboration between CHDP and the MCAH led team of the national Assuring Better Child Health and Development (ABCD) Screening Academy Project. The work to enhance California's capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children, ages 0-5, continues through the Statewide Screening Collaborative (SSC), which served as the stakeholders in the ABCD project.

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age California Project Launch. /2012/ Project Launch's goal is to show the feasibility and impact of recommended policy changes to establish and maintain a developmental continuum that prepares children to learn. //2012//

/2013/California Home Visiting Program staff has recently convened the State Interagency

Team (SIT) Workgroup, whose stakeholder members include ECCS and California Project LAUNCH (CPL). SIT will work to improve the quality, efficiency and effectiveness of home visiting through interagency collaboration.//2013//

>Child Health and Disability Prevention (CHDP) Program
CMS administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, called the CHDP Program. CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the Gateway process

CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutrition assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

>Comprehensive Perinatal Services Program (CPSP)
CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women. There are 1566 active CPSP providers in California /2012/(1592 for 2010)//2012//. MCAH develops standards and policies; provides TA and consultation to the local perinatal services coordinators; and maintains an ongoing program of training for all CPSP practitioners throughout the state. Local MCAH staff /2012/ monitor service delivery, recruit new providers and//2012// offer TA and consultation to potential and approved providers in the implementation of CPSP program standards.

>Fetal Infant Mortality Review Program (FIMR)
Sixteen local LHJs have FIMR Programs that enable them to identify and address contributing factors to fetal and infant mortality. A Case Review Team examines selected fetal and infant death cases, ***/2013/ conducts maternal interviews, //2013//*** identifies factors associated with these deaths, and determines if these factors represent systems problems. Recommendations from the Case Review Team are presented to a Community Action Team that develops and implements interventions that lead to positive changes. ***/2013/ MCAH is building an aggregated database with data reporting from all 16 jurisdictions//2013//***.

>Genetically Handicapped Persons Program (GHPP)
GHPP provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 4.6 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

GHPP client enrollment is stable, with 1750 clients for 2008-2009. ***/2013/GHPP client enrollment for 2010-2011 was 1537.//2013//***

> Hearing Conservation Program (HCP)
HCP helps to identify hearing loss in preschoolers to 21 years of age in Public Schools. All school districts are required to submit to CMS an annual report of hearing testing. ***/2013/ For2009/10, 780 school districts reported their hearing screening results and 1.9 million students were screened. //2013//***

>Health Care Program for Children in Foster Care (HCPCFC)
HCPCFC is a public health nursing program ***/2013/ administered by the local CHDP Program, is //2013//*** located in county child welfare service agencies and probation departments to provide public health nurse expertise in meeting the medical, dental, mental and developmental needs of

children and youth in foster care.

>High Risk Infant Follow-up (HRIF)
Infants discharged from CCS-approved NICUs are followed in NICU HRIF clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

The HRIF program continues to provide three multidisciplinary outpatient visits to identify problems, institute referrals, and monitor outcomes. The QCI developed a web based reporting system to collect HRIF data for quality improvement activities. Statewide trainings were provided to all NICU and HRIF Program staff before implementation and a follow-up training was held in February 2010.

/2012/
>California Home Visiting Program (CHVP)
CHVP aims to improve service coordination for at-risk communities to promote improvements in maternal and infant health, school readiness, reduction of child maltreatment, improved community referral systems, and reductions in crime and domestic violence. //2012// ***/2013/The focus will be on the implementation of two evidence-based home visiting models: Nurse Family Partnership (NFP) and HF America.//2013//***

>Human Stem Cell Research Program (HSCR)
HSCR develops comprehensive guidelines to address the ethical, legal, and social aspects of stem cell research and ensure the systematic monitoring and reporting of HSCR activity that is not fully funded by Proposition 71 money granted through the California Institute for Regenerative Medicine. A diverse group of 13 national and international specialists serve on a HSCR Advisory Committee to advise CDPH on statewide guidelines for HSCR.

>Local Health Jurisdiction (LHJ) Maternal Child and Adolescent Health Programs (LHDMP)
61 LHJs receive Title V allocations that support local infrastructure, including staff, to conduct culturally sensitive collaborative and outreach activities to improve services for women and children, refer them to needed care, and address state and local priorities for improving the health of the MCAH population.

>MCAH Toll-free Hotline
MCAH staff responds to calls and refer callers to local MCAH programs. LHJs also have local toll-free numbers that provide information and referrals to clients. Local MCAH contact information is made available online.

>Medical Therapy Program (MTP)
MTP provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. MTP conducts multidisciplinary team conferences to support case management and care coordination. The number of clients enrolled in the MTP has shown a slight declining trend over the past 5 years of 7% and is currently 24,777 /2012/in 2010 and 24,433 for 2011.//2012//

>Newborn Hearing Screening Program (NHSP)
NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills. In California, 243 hospitals are certified to participate in the NHSP as of December 2009. ***/2013/Five hospitals were pending certification and 253 hospitals certified as Inpatient Infant Hearing Screening Providers.//2013//***

>Pediatric Palliative Care Waiver Program
This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or

life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports and emergency room visits in addition to other costs avoided while the child is enrolled in the program. ***/2013/As of March 2012, there were 9 active hospice or home health agency providers.//2013//***

>Regional Perinatal Programs of California (RPPC)
RPPC promote access to risk-appropriate perinatal care to pregnant women and their infants through regional QI activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care. In addition the local perinatal advisory councils perform hospital surveys and perinatal assessments of regional and statewide significance; develop communication networks locally; disseminate educational materials and produce a statewide newsletter; provide resource directories, referral services, and hospital linkages to the Northern and Southern CPeTS; and assist hospitals with QI activities, data collection protocols, and quality assurance policies and procedures. ***/2013/ Production of a newsletter was terminated.//2013//***

CPeTS maintains a web-based bed availability list, locate beds for high-risk mothers and infants and provide transport assistance, transport data reports, and perinatal transport quality improvement activities, including emergency triage and transport in the event of a disaster. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers.

>Sudden Infant Death Syndrome (SIDS) Program
SIDS is funded in all 61 LHJs to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. The SIDS Program provides statewide technical assistance and support to healthcare and public safety personnel and parents including education about SIDS, grief counseling, and information on prevention to reduce the risk of SIDS.

Technical Assistance
MCAH places high priority on providing stakeholders and partners with quality assistance where necessary to improve MCAH program performance. The following programs were created to address the developmental assistance needs in the state:

>Breastfeeding Technical Assistance Program
This program promotes and supports efforts to make breastfeeding the infant feeding norm. Its website (http://www.cdph.ca.gov/programs/breastfeeding/Pages/default.aspx) contains targeted breastfeeding information for families and providers. It has piloted BBC to assist hospitals to improve their exclusive breastfeeding rates and collaborated with MediCal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

/2013/
> Nutrition and Physical Activity Technical Assistance Initiative
This integrates healthy eating and physical activity promotion within MCAH and its local programs. Strategies include providing technical assistance, development of healthcare policies, training and guidelines; supporting partners in coalition building; and using epidemiological information to design, implement, and evaluate nutrition and physical activity initiatives.//2013//

>Oral Health Technical Assistance Program
Oral Health Program provides local technical assistance and state level coordination and collaboration to address the oral health needs of pregnant women, mothers, children and adolescents, especially within low-income families, by expanding access to dental care and preventive services, and by encouraging local MCAH Programs to work in collaboration with new and existing dental and health-related programs. This year, 18 local MCAH programs have chosen oral health as a priority objective. Another 25 /2012/ 21 //2012//local MCAH programs collaborate on various community tasks forces involving oral health issues. Further, direction has

been provided by updating oral health educational components in the CPSP "Steps to Take" Guidelines, BIH prenatal and postpartum curriculums, AFLP "Infant Feeding" Guidelines and CDAPP's Sweet Success Guidelines. /2012/MCAH is disseminating perinatal clinical oral health guidelines to assist providers deliver oral health services.//2012//

>Preconception Health and Healthcare
MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age. /2012/Reproductive life planning concepts and tools are being integrated into BIH and AFLP programs.//2012// ***/2013/MCAH provides preconception health training and technical assistance.//2013//***

Major Collaboratives
MCAH and CMS value the input provided by its stakeholders across communities and has actively fostered collaboratives, task forces and advisory/work groups to address MCAH and CSCHN health issues. These collaboratives, task forces and advisory/work groups also serve to coordinate preventive and health care delivery with other services at the community level as well as with the health components of community-based systems. These include the following:

> Adolescent Sexual Health Work Group (ASHWG)
ASHWG is a collaborative of 23 organizations from CDPH, CDE and non-governmental organizations who address sexual and reproductive health needs of youth. Its vision is to create a coordinated, collaborative, and integrated system among government and non-government organizations to promote and protect the sexual and reproductive health of youth in California. Current activities focus on core competencies for /2012/youth//2012// providers and educators, integrated data tables (available at: http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf) and youth development.

>California Perinatal Quality Care Collaborative (CPQCC)
CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. For 2010, CPQCC membership is at 128 NICUs, with all of the 114 CCS-approved NICUs as members/2012/; for 2011, there were 129 NICUs, with 115 CCS-approved NICUs as members.//2012//. ***/2013/CPQCC includes hospitals representing over 90% of all neonates cared for in NICUs,//2013//***

The Perinatal Quality Improvement Panel (PQIP), is a standing subcommittee of CPQCC, that provides oversight for all quality functions of CPQCC by creating, initiating and conducting statewide quality projects and/or prospective trials; publishing and disseminating new and updated QI toolkits; analyzing the CPQCC database and designing supplemental data collection tools; and initiating and implementing research projects focused on QI. /2012/PQIP revised its charter and re-designed its structure, developing 4 sub-committees.//2012// ***/2013/ The goal is to support benchmarking and performance improvement activities and improve newborn delivery room management. //2013//***.

> California Maternal Quality Care Collaborative (CMQCC)
CMQCC is the statewide umbrella organization for assessing the current state of knowledge of maternal illness and complications and transforming this knowledge into targeted, evidence-based, data-driven clinical quality improvement interventions and public health strategies statewide and at the local level. CMQCC's mission is to end preventable maternal morbidity and mortality by improving the quality of care women receive during pregnancy, childbirth, and postpartum. CMQCC maintains an informative website of resources and policies for both public and private use (www.cmqcc.org) and provides educational outreach to health professionals /2012/ CMQCC convenes the Pregnancy-Associated Mortality Review (PAMR) Committee and

provides TA to local maternity care quality improvement projects. CMQCC also developed and disseminated two toolkits for obstetric care providers: "Improving the Health Response to Obstetric Hemorrhage" and "Eliminating Non-Medically Indicated Deliveries Before 39 Weeks of Gestational Age". //2012// ***/2013/ CMQCC is preparing a third toolkit to improve identification and effective therapy for preeclampsia/eclampsia and is developing a maternal data center to track maternity care quality improvement efforts.//2013//***

Family Voices of California (FVCA)
FVCA helps CSCHN families through a coordinated network of regional, family-run FVCA Council Member agencies. FVCA continues to provide information to families and professionals on issues relating to a Medical Home, including organizing healthcare information and navigating health systems.

FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment. FVCA has ensured that parents and community members are involved in these processes, has provided financial support to families to enable their involvement, and has facilitated providing parent and community member input through key informant interviews and focus groups.

/2012/>Maternal Quality Indicator (MQI) workgroup
The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic conditions that compromise maternal health ***/2013/analyzes composite healthcare costs of maternal morbidities. //2013//*** and suggests strategies for monitoring quality benchmarks for obstetric hospitals.//2012//

>Prenatal Substance Use Prevention
MCAH's efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California Fetal Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, (DSS, Department of Mental Health (DMH), CDE, Department of Developmental Services (DDS) and ADP acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD. ***/2013/The FASD Workgroup gave its recommendations in May 2010.//2013//***

MCAH LHJs have identified perinatal substance use prevention as a priority. They have engaged in community mobilization and capacity building, and implemented screening, assessment, and referral to treatment programs that address their particular needs.

>Preconception Health Council of CA
One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and MOD, California Chapter. In May 2009 the PHCC launched its official website: www.everywomancalifornia.org, which is supported by Title V funds. The website contains information for both consumers and providers and includes an interactive section for health professionals featuring discussion forums, opportunities for networking and resource-sharing, and an event calendar. MCAH also received a First Time Motherhood grant from HRSA/MCHB to develop a preconception health social marketing campaign reaching women at increased risk for poor pregnancy outcomes. ***/2013/ The Interconception Care Project of California and the California Guidelines for Preconception Care were developed through the PHCC. //2013//***

>Transition Workgroup

CMS recognizes the importance of transitioning health care for CSHCN from pediatric to adult services. During site reviews of new SCCs and CCS programs, the issue of health care transition planning and age and developmentally appropriate care for CSHCN is reviewed and discussed.

CMS formed a statewide Transition Workgroup comprised of healthcare professionals, experts in transition care, former CCS clients and family representatives who worked together on the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released in 2009, as a CCS Information Notice.

CMS collaborates with the California Health Incentives Improvement Project (CHIIP) and funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services. As staffing allows, CMS will participate on the CHIIP Youth Transition Advisory Committee.

Business Partners
To further enhance current capacity to provide community based preventive and health care services, expertise in health related services through provision of technical assistance is improved via contractual relationships with clinical and academic health experts. These include:

/2012/ > Advanced Practice Nurse Program (APN)
APN maintains accredited advanced practice nursing programs. The program goals are to (increase the availability of quality reproductive health care services for childbearing women in underserved areas by preparing nurses in a program that meets state and national guidelines and recruit and enroll students.//2012// ***/2013/APN was eliminated effective July 2012.//2013//***

>Branagh Information Group
MCAH contracted with the Branagh Information Group to develop, maintain and provide technical assistance for LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their children. Branagh Information Group also was contracted to develop and maintain BIH Management Information Services (MIS), a software package for BIH agencies conducting case management. ***/2013/Branagh Information Group provide Help Desk support and training for the BIH MCAH MIS, a new database for BIH.//2013//***

>The California Adolescent Health Collaborative (CAHC)
MCAH has a contract with CAHC to provide adolescent health expertise, address current adolescent health concerns through technical assistance to the local MCAH programs and other partners. CAHC also supports core activities of ASHWG. /2012/ Through Internet Sexuality Information Service, CAHC reaches adolescents using digital media. //2012//

>California State University, Sacramento (CSUS)
CSUS provides /2012/ and coordinates //2012// CPSP Provider /2012/ Overview and Steps To Take //2012// Training, is developing on-line provider training, and supports statewide /2012/CPSP//2012// meetings.

>Childhood Injury Prevention Program
To reduce injury-related mortality and morbidity among children and adolescents, MCAH contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical support for local MCAH programs and their partner agencies via face to face meetings, teleconferences, e-mail, a list serve, and literature reviews of the latest injury prevention research.

>Family Health Outcomes Project (FHOP) at the University of California, San Francisco
FHOP provides technical assistance and training, analyzes data for LHJs, provides a current web listing of useful resources, assists in establishing guidelines, and prepares special state reports

for MCAH and CMS./2012/FHOP is working with CMS on developing and implementing a family survey for use over the next 5 years.//2012//

>Health Information Solutions
With direction from MCAH, Health Information Solutions developed and maintains the Improved Perinatal Outcomes Data Reports (IPODR) website. IPODR allows users to view and download the most recent demographic and hospital data about California mothers and infants. The data are available in tables for the most recent year available, in maps aggregating the past three years, and in graphs displaying a 15-year trend. Information is available at the state, county, and zip code levels.

>Perinatal Profiles at the School of Public Health, University of California at Berkeley
This project produces an annual report that provides information on sentinel indicators of perinatal quality care for all the maternity hospitals and regions in California that may reveal where efforts are needed for the purpose of continuous quality improvement.

/2012/ >Public Health Institute (PHI)
Together with MCAH, PHI conducts medical record abstraction and assists in the data analysis for -PAMR.//2012//

>Maternal and Infant Health Assessment (MIHA) with the Center on Social Disparities in Health, University of California in San Francisco
MIHA is an annual survey that collects population-based information about maternal health status, health behavior, knowledge, and experiences before, during and shortly after pregnancy. Findings are disseminated through conference presentations, reports and posting of survey results through the MCAH website.

Select Statewide Programs Serving the MCAH Population
Medi-Cal and HF provide California's low-income children with access to comprehensive primary and preventive services, including dental care. Medi-Cal covers children ages 1 through 5 living in household up to 133% of FPL, children and adolescents ages 6 to 19 at up to 100% of FPL, and young adults ages 19 to 21 at up to 86-92% of FPL. HF covers children up to age 18 who are uninsured and in households up to 250% of FPL. Monthly premiums and co-payments for certain types of visits and prescriptions are required.

As of January 2010, there were 878,005 children enrolled in HF, an approximately 1.6% decrease from the previous year. Of those children, approximately 2.9% (25,878) are being served by CCS for their special health care needs.

Specific to infants, Medi-Cal, HF and Access for Infants and Mothers (AIM) provide health insurance for infants. Medi-Cal reaches infants in households below 200% of FPL. HF reaches infants in households up to 250% of FPL; monthly premiums and co-payments are required. AIM provides state-subsidized third party insurance for infants in households at 200-300% of FPL.

State law requires MRMIB to enroll infants of AIM mothers into HF. AIM infants above 250% will be able to continue in HF up to 2 years of age before having to meet current eligibility. As of January 2010, CCS serves 418 AIM children. /2012/ As of February 2011, 865,480 children were enrolled in HF. Of these, 2.6% (22,130) are served by CCS.//2012//

Rehabilitation services
Services such as physical therapy for SSI beneficiaries under the age of 16 with a CCS medically-eligible diagnosis are served by MTP. Children with mental or developmental conditions receiving SSI are served by the DMH, DDS and CDE. In FY 2009-2010, CCS received 86 referrals. Of these, five were not medically eligible for CCS and two could not be verified. CCS will continue to work with the Disability Evaluation Division to train local staff to conduct CCS medical eligibility evaluations which should result in fewer referrals to CCS.

Family-centered, community-based coordinated care (FCC) for CSHCN
SCCs and hospitals that treat CSHCN who wish to become CCS-approved must meet specific criteria, for FCC. FCC is assessed and recommendations are made as part of the review process by the CMS Branch.

CCS facilitates FCC services for families of CSHCN. CCS allows a parent liaison position in each county CCS to enable FCC. County programs assist families to access authorized services, such as pediatric specialty and subspecialty care, and provide reimbursement for travel expenses, meals, and motel rooms during extended hospital stays. Many county CCS are terminating parent liaison contracts due to state budget cuts.

In 2009 the Children's Regional Integrated Service System (CRISS) annual FCC conference focused on mental health services for children and youth with special health care needs. The conference was co-sponsored with the University Center on Excellence in Developmental Disabilities (UCEDD), FVCA, and CMS. /2012/In 2010 CRISS FCC conference was "Working Together in Challenging Times: CCS, Families and the Community".//2012//

The CRISS NICHQ project to promote medical homes for children with epilepsy in a Sonoma County Federally Qualified Health Center (FQHC) was completed in 2009. CRISS worked with the Sonoma County CCS program to take on responsibility for continuing to convene the project's local oversight committee, and FQHC is continuing activities to support medical homes for children with epilepsy.

Additionally, CRISS makes the parent health notebook and other medical home materials available on its website www.criss-ca.org. ***/2013/ /CCS is partnering with CRISS to provide local medical home projects. The Alameda Medical Home Project is implemented through provider training in medical home concepts, resources, and referral pathways with pediatric practices and clinics.//2013//***

L.A. Partnership for Special Needs Children (LAPSNC), which promotes parent involvement in meetings and on committees, cosponsored an all-day conference entitled "Weathering Difficult Times: Resources for Children with Special Needs and their Families". Parents served on the planning committee for this meeting and 130 providers and parents were in attendance. /2012/LAPSNC is planning a conference in 2011 focusing on the impact of the 1115 waiver on CSHCN.//2012//

FVCA continues its active role as a significant resource for families and professionals on issues relating to a medical home, including organizing healthcare information and navigating health systems.

In 2009, FVCA created a youth council, Kids As Self Advocates (KASA), that meets once a month via conference call and face to face every other month. CCS has attended some of the KASA meetings, and KASA youth have provided input to CCS on transition issues. KASA youth have received leadership training, and FVCA provides staff time for a youth group coordinator and provides youth with stipends for participation at meetings and travel.

In addition to youth leadership training, FVCA is developing the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making and has piloted trainings at the annual Family Resource Supports Institute.

In 2009, FVCA was a collaborative member of "Partners in Policymaking" and worked to provide leadership training to 35 self-advocates and parents of children with developmental disabilities in L.A. County. The 2010 training will be in San Bernardino County.

Over the last eight years, FVCA in collaboration with advocates across the state convened annual

statewide Health Summits that have brought together families, professionals, agency representatives, advocates, insurers, health policy experts and legislators to discuss access to affordable and appropriate health care for CSHCN and to develop strategies to address the challenges families face. FVCA funds this conference through its federal MCHB grant and private sponsors, thus providing families with travel scholarships and stipends to be able to attend.

Other FVCA 2009 activities have included: Council's monthly meetings to address parent and community involvement; hosting 9 statewide webinars for families and professionals on topics such as the Family Opportunity Act, health care transition, nutrition for CSHCN, and impacting legislators; and participation in the Prematurity Coalition's Summit, providing and organizing a panel on Home Based Community Care to address parent and community involvement during and after hospital stays for families with babies born prematurely.

In 2009 and 2010, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. FVCA has provided financial support to families to enable their involvement, and has facilitated parent and community member input for interviews, focus groups, and surveys. ***/2013/FVCA and CCS hold monthly webinars with families of CSHCN.//2013//***

Approaches to Culturally Competent Service Delivery
Because California is a cultural melting pot, it is paramount that both MCAH and CMS interact and provide services in a culturally, linguistically and developmentally competent manner with people of diverse backgrounds. Both MCAH and CMS value and respect the diversity of clients our programs serve. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. Both MCAH and CMS have mechanisms to promote culturally and linguistically competent approaches to service delivery such as:
> BIH delivers culturally competent services to address the problem of disproportionate African American maternal and infant mortality.
> ***/2013/CDAPP Resource and Training Center has brochures, teaching aids and a food guide in various languages.//2013//***
> MCAH and CMS collect and analyze data according to race, ethnicity, age, etc. to identify disparities.
> MCAH and CMS program materials are mostly published in English and Spanish, and translated to other languages as needed.
> FIMR has posted a guide and tool on the MCAH website for assessing cultural and linguistic competence among their funded agencies.

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshé is the Secretary for the California Health and Human Services Agency (CHHSA), which is a cabinet-level position that reports directly to the Governor. Mark B. Horton, MD, MSPH is the Director of the CDPH, which is one of thirteen departments in CHHSA together with the DHCS. David Maxwell-Jolly, Ph.D. is the Director of DHCS.

/2012/ In November 2011, Edmund "Jerry" G. Brown, Jr. was elected to replace Arnold Schwarzenegger as the Governor of California. Shortly thereafter Diana Dooley was appointed to replace S. Kimberly Belshé as the Secretary for CHHSA. In March 2011, Howard Backer, MD, MPH replaced Mark B. Horton, MD, MPH as the Interim Director of the CDPH. Toby Douglas replaced David Maxwell-Jolly, Ph.D. as the Director of DHCS. //2012//

/2013/ On June 13, 2011, Ron Chapman, MD, MPH, was sworn in as director of CDPH by

CHHSA Secretary Diana S. Dooley. //2013//

The State of California designates CDPH to administer the MCAH Program.[35, 36] MCAH has the primary responsibility for carrying out Title V functions, the MCAH program, and other similar programs that include the HSCR and Cord Blood Banking Program and CBDMP. MCAH reports directly to CDPH's CFH, which is one of five centers responsible for carrying out CDPH's core activities.[37] Catherine Camacho is the Deputy Director of CFH, a position she's held since CDPH was established in July 2007.[38] Vickie Orlich is the Assistant Deputy Director for CFH.

/2012/ In response to the United States' Patient Protection and ACA of 2010, which President Obama signed into law in March 2010, the MCAH Program created the Home Visiting Program (HVP), which manages the ACA's Maternal, Infant, and Early Childhood Home Visiting Program. //2012//

MCAH coordinates with DHCS' CMS Branch to handle Title V activities related to CSHCN.

Information about MCAH is provided in the sub-sections below. Information about CMS Branch is available in Section III D. For updated organizational charts for MCAH and CMS Branch, see the attachments to Sections III C and III D, respectively.

>Maternal Child and Adolescent Health Program (MCAH)
Shabbir Ahmad, PhD, has acted as Chief of MCAH since June 2007. Les Newman is the Assistant Chief, a position he has held since February 2001. MCAH includes professionals from various clinical, public health, and scientific disciplines.

MCAH consists of six branches:
- Epidemiology, Assessment and Program Development
- Fiscal Management and Contract Operations
- Program Allocations, Integrity and Support
- Program Standards
- Policy Development
- California Birth Defects Monitoring Program

/2013/ As of January 2012, Christine Nelson, replaced Les Newman as the Assistant Chief. //2013//

> Epidemiology, Assessment and Program Development (EAPD) Branch
EAPD Branch analyzes and assesses program and population-based data and information that allow MCAH to monitor program implementation, evaluate program effectiveness, develop policies, and allocate appropriate resources. EAPD Branch also oversees the compilation of all federal Title V reporting requirements for the annual block grant application/report and statewide five-year needs assessment.

Mike Curtis, Ph.D., is the Acting Chief of EAPD Branch, a position he held since June 2007. EAPD Branch consists of two sections with a total of 19 staff positions:
- Epidemiology, Evaluation and Data Operations
- Surveillance, Assessment and Program Development

EAPD Branch also houses the Human Stem Cell Research and Cord Blood (HSCRCB) Program, which is responsible for implementing legislation mandating the monitoring of stem cell research in California.[39]

> Fiscal Management and Contract Operations (FMCO) Branch
FMCO Branch assumes the contract monitoring functions for MCAH, including fiscal forecasting, budget-related work, management of over 400 contracts, and working with Department of

Finance and other control agencies. Jo Miglas is the Chief of the FMCO Branch, a position she's held since 2007.

FMCO Branch consists of three units with a total of 23 staff positions:
- Accounting and Business Operations
- Maternal, Child and Adolescent Health Contracts and Grants.
- Office of Family Planning Allocation and Matched Funding

> Program Allocation, Integrity and Support (PAIS) Branch
PAIS Branch undertakes activities associated with allocation and matched funding of MCAH programs; program integrity; special projects and administrative activities associated with more than fifteen MCAH programs, including bill analysis and regulation development; policies and procedure development; administrative activities related to management analysis, personnel, training, and procurement; and information technology management, including website maintenance, local area network support, and management of servers, hardware, software, and inventory. Fred Chow is the Chief of the PAIS Branch, a position he has held since 2007.

PAIS Branch consists of three units with a total of 18 positions:
- Allocation and Matched Funding
- Special Projects and Administrative Support Unit
- Information Technology Unit

> Program Standards Branch (PS)
The Program Standards Branch coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, Advanced Practice Nursing program, BIH, CPSP, and local MCAH programs. PS program consultants provide consultation and technical assistance to LHJs and other organizations. Anita Mitchell, MD is the Chief of PS Branch, a position she has held since July 2005. Dr. Mitchell is board certified in Pediatrics. The PS Branch consists of a total of 11 staff positions.

/2012/ In August 2010, Karen Ramstrom, DO, MSPH, replaced Anita Mitchell, MD as the Chief of the PS Branch. //2012//

> Policy Development (PD) Branch
PD Branch develops the policy and procedures in support of all MCAH programs and collaborates on Federal, State, and local levels, providing expertise on multiple health priorities including nutrition, obesity, breastfeeding, physical activity, oral health, ECCS, preconception health, FIMR, SIDS, RPPC, CPeTS, CDAPP, CMQCC, CPQCC and BIH program development. PD Branch identifies relevant data points for annual reporting to ensure that LHJs address state priorities and program requirements.

Karen Ramstrom, DO, MSPH, is the Chief of PD Branch, a position she has held since May 2006. Dr. Ramstrom is board-certified in Preventive Medicine and Family Medicine. PD Branch consists of eleven staff positions.

/2012/ In August 2010, Connie Mitchell, MD, MPH, replaced Karen Ramstrom, DO, MSPH as the Chief of the PD Branch. //2012//

> California Birth Defects Monitoring Program (CBDMP)
CBDMP is legislatively mandated to provide surveillance of birth defects and maintains a birth defect registry. CBDMP joined MCAH in January 2007. [35] Marcia Ehinger, MD, board-certified in pediatrics and clinical genetics, is the Chief of CBDMP, a position she has held since July 2007.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Information about the MCAH Program is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below.

The CCS program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Sections 123800-123995. GHPP, which provides services to individuals with certain genetic conditions, is authorized by the Health and Safety Code Division 106, Part 5, Chapter 2, Article 1, Sections 125125-125191. The CHDP program, California's preventive healthcare program for children, is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 6, Sections 124025-124110 and by Division 103, Part 3, Chapter 1, Article 1, Section 104395. NHSP is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Section 123975 and Article 6.5 (commencing with Section 124115).

Louis Rico, Chief, Systems of Care Division is Acting Chief for the CMS Branch until a replacement can be recruited for the position. The CMS Branch was reorganized in 2005. The Branch is composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology. /2012/Louis Rico, is no longer Acting Chief for the CMS program, but continues as Chief of the Systems of Care Division with its oversight of the CMS program. On November 1, 2010, Dr. Robert Dimand, under a new organizational structure, became the Chief Medical Officer for CMS with responsibilities for medical oversight and direction including policy development and revision. Dr. Dimand comes to CMS from his previous position as Professor and Chair of the Dept. of Pediatrics at UCSF Fresno and Chief of Pediatrics at Children's Hospital of Central California. He is fellowship trained in Pediatric Critical Care Medicine and Pediatric Gastroenterology.

There are currently seven sections: Program Development, Dependent County Operations, Independent County Operations, Statewide Programs, Program Support, Information Technology, and Waiver and Research.

On November 1, 2010, under a new organizational structure, Stephen Halley became the Chief Operations Officer for CMS with responsibilities for operational oversight and direction as well as operations and administrative policy. Mr. Halley joined CMS in July 2010 as Assistant Branch Chief replacing Harvey Fry who held the position from January 2005 through 2008. Mr. Halley had been in private consulting and had worked with a number of state departments. He was also a former hospital administrator.//2012//

/2013/ In the new organizational structure, the Chief Medical Officer oversees the Statewide Medical Services Branch, which is comprised of 7 medical consultants, 3 nurses, and the Medical Policy and Consultation Section. Dr. Joseph Schulman, MD, a nationally recognized leader in Neonatal Medicine and Quality Outcomes, and the lead author on a manuscript describing the optimal approach to CLABSI in New York has joined CCS. He is coordinating the multidisciplinary efforts around CLABSI, Health Care Associated Complications and "never events" in the NICU.
//2013//

> Program Development Section (PDS)

PDS is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines. Jill M Abramson MD, MPH is the Chief of the Program Development Section. She is a board certified pediatrician and is board eligible in Preventive Medicine. PDS has 15 positions. /2012/PDS has 13 positions.//2012// ***/2013/The section was renamed Medical Consultation and Policy Section (MPAC) and now has 8 positions. The new section is responsible for program policy, statewide consultation and***

medical consultation.//2013//

The PDS Section consists of three units: the Program Policy and Analysis Unit, the Research Unit and the State Consultation Unit. The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of HRIF and Pediatric Palliative Care programs; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and provide pediatric consultation to Medi-Cal and other DHCS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP, and implementation of a new delivery system that enhanced access to medical foods and improved clinical management for metabolic patients. /2012/The unit facilitates negotiations and claims processing for out-of-state providers when a child enrolled in CCS is treated in another state either emergently or electively.//2012//

The Research Unit consists of three research staff responsible for program data retrieval, aggregation and analysis for the CCS and CHDP programs. /2012/ In 2010, a new Research and Waiver Section was created. The Research Unit which was under the Program Development Section was transferred and merged with the Waiver unit to form the Research and Waiver Section.//2012//

The Statewide Consultation Unit staff provide TA in the disciplines of medicine, nursing, social work, nutrition, dentistry, dental hygiene, and physical therapy and participate in the evaluation and monitoring of county CCS and local CHDP programs for compliance with federal and state regulations and local policies and procedures. Staff in the unit are also responsible for ensuring that all providers who deliver services to children are qualified and in good standing with the appropriate board under the Department of Consumer Affairs and for assisting with on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures.

/2012/>Waiver and Research Section
Don Fields is Chief of the Waiver and Research Section. The Section is comprised of two units the Waiver Unit and the Research Unit.

The Waiver Unit, with 14 positions, has the responsibility for implementing the CCS portion of the Federal 1115 Waiver. The Waiver Unit will implement the CCS pilot programs that will redesign the CCS Program in certain geographic areas to provide the full-range of health care benefits to children with CCS eligible medical conditions, including primary and preventative services. The new system of care will maintain CCS provider standards and require the delivery of services to eligible children by facilities and individual providers who meet these standards. The implementation will include contract development, a readiness review, enrollment and contract management of the pilots.

The Research Unit consists of six research staff responsible for program data retrieval, aggregation and analysis for the CCS and CHDP programs. The research staff will also design and implement the enrollment process for the CCS pilots.//2012//

/2013/ The Waiver and Research Section is also responsible for two Disease Management Programs for Seniors and Persons with Disabilities (SPDs) with chronic conditions or major medical conditions.. These programs provide coordinated care to SPDs in designated counties.//2013//

> Regional Operations Section (ROS)

ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and L.A.. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, including review and approval of EPSDT Supplemental Services requests, resolution of financial appeals, determination of eligibility for MTU services, and program consultation/TA.

Regional office professional staff also have oversight responsibilities for local CCS and CHDP programs, including evaluating and monitoring county CCS and local CHDP programs for compliance with federal and State regulations and local policies and procedures. Oversight responsibilities include, but are not limited to, program development, review and approval of annual budgets and work plans, and provision of TA and program consultation.

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units.

V. David Banda is the ROS Section Chief, a position he has held since December 2008. He was manager of the CMS Hearing & Audiology Services Unit/NHSP for 10 years and has more than 30 years of experience in the Department. In 2009, the Governor's budget eliminated 12 positions. ROS now has 40 positions. /2012/ROS is currently identified as Dependent County Operations Section and Independent County Operations Section.

James Delgado is the Acting Section Chief for the Dependent County Operations and has held that position since November 1, 2010. Prior to this position, Mr. Delgado was a manager in the DHCS Medical Case Management Program for approximately 10 years. There are 44 positions in this Section.//2012//

/2013/ As of June 2, 2011, James Delgado was appointed as the Section Chief for the Dependent County Operations Section (DCOS) formerly known as the Sacramento Regional Operations Section. Mr. Delgado has 25 years of state service. Of the 44 positions within DCOS, 34 positions are in Sacramento and 10 positions in L.A.. //2013//

/2012/ The Section Chief for the Independent County Operations is currently vacant. V. David Banda is the Section Chief for Independent County Operations. There are 41 positions in this Section.//2012// ***/2013/ The Section Chief for the Independent County Operations is Janis Fong. There are 38 positions in this Section.//2013//***

> Statewide Programs Section (SPS)
The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities. Joleen Heider-Freeman is the Section Chief of SPS as of May 2005. The SPS currently has 24 filled positions. The SPS vacant positions have been cut due to the Governor's Balanced Budget Reduction Act. /2012/The SPS currently has 27 filled positions and 1 vacant position. Joleen Heider-Freeman retired as of April 8, 2011. V. David Banda is the Section Chief of SPS since April 11, 2011.//2012/ ***/2013/The SPS currently has 14 filled positions and six vacant positions//2013//***

There are three units within the section: Specialty Programs, Hearing and Audiology Services, and GHPP. The Specialty Programs Unit is responsible for the monitoring of the HCPFC, identifying CHDP administrative needs and priorities and initiates efforts to accomplish CHDP objectives, and offers TA with the Transition Planning Statewide Guidelines. ***/2013/SPS is offering TA with CCS Transition Planning.//2013//***

The Hearing and Audiology Services Unit is responsible for the maintenance and monitoring of NHSP and for providing consultation/TA to providers and local programs regarding program

benefits. The Unit is also responsible for the development and implementation of the NHSP Data Management Service (DMS). Staff in the unit monitor contracts with NHSP Hearing Coordination Centers (HCCs) providing follow-up testing and treatment services to infants with suspected hearing loss; evaluate and certify school audiometrists; and provide TA for the CHDP providers on the audiometric testing of hearing for children in the school setting.

The Hearing and Audiology Services Unit develops and implements NHSP and CCS policy relating to hearing services. Monitoring and quality assurance activities are conducted with NHSP contractors and CCS providers. GHPP provides all medical and administrative case management services for approximately 1750 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia). /2012/GHPP has 1800 clients.//2012// ***/2013/GHPP has 1540 clients//2013//***

> Program Support Section (PSS)
PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Section Chief is Erin M. Whitsell. She has held the position since 2003. There are currently 17 positions in PSS. /2012/Since Fall 2010, PSS is composed of two units: Administrative and PSU.//2012// ***/2013/Effective November 2011, Joseph De La Torre became the Section Chief of PSS.//2013//***

The Administration Unit is responsible for fiscal, personnel, contracting, purchasing and business services for CMS. Staff in the unit review, approve, and process CCS county and CHDP county/city invoices; resolve invoicing/payment issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. /2012/These activities are for all Systems of Care Division (SCD) staff.//2012//

The Provider Services Unit (PSU) is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary. Staff in PSU also process hospital approval updates and all special care center directory updates and works with Information Technology staff in posting updates to various sites. Staff also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in statewide formal training seminars.

The Clerical Support Unit provides general clerical support to the CMS Branch management and staff. The unit is responsible for completion of complex typing assignments; assisting in organizing and filing all program documents; respond to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and, makes travel arrangements for staff. /2012/ Clerical Support Unit has merged with PSU. PSU also provides general clerical support to the SCD management and staff. The clerical support staff assist in organizing and filing all program documents; respond to telephone calls, faxes, and e-mails; and disseminate program information to State staff, local agencies, the general public, and various other organizations.//2012//

> Information Technology Section (ITS)
ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the State Health and Human Services Agency Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application. /2012/This is hosted at the Office of Technology Services'(OTech) Data Center.//2012// Brian Kentera was appointed Chief in February 2008. The CMS Net system is

used by the county and State Regional CCS offices to manage the health care of approximately 170,000 children. /2012/The CMS Net system is used for managing the cases of 185,000 CCS and 1800 GHPP clients.//2012// ***/2013/The CMS Net system is used for managing the cases of 177,000 CCS and 1500 GHPP clients.//2013//***
The section is divided into two units: Information Systems and Information Technology. This section provides consultation to OTech, a division within the Office of the State Chief Information Officer, formerly the California Department of Technology Services. ITS currently consists of 11 State staff and 9 contractors.

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

MCAH and CMS are the primary entities in California that provide core public health and essential health care services for mothers, infants, children and CSCHN through its Title V programs. This requires involvement at the community, local and state level and seeking out of community based organizations (CBOs), building intra and inter-agency collaboration, partnering with universities, health foundations, hospitals and health professional organizations and working with individuals we serve. Both MCAH and CMS provide leadership in working with these various stakeholders to identify and focus our priorities, establish a process and create a plan to address these priorities and demonstrate progress in meeting these priorities.

Both MCAH and CMS actively foster statewide collaboratives and partnerships. A detailed discussion of our major collaboratives and partnerships was included in Section III-B, Agency Capacity.

> Department of Education (CDE)
MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children.

CMS and CDE work collaboratively to assure all infants with hearing loss identified through the NHSP are referred to Early Start. The MCHB grant supports improvement of services for early identification and intervention of hearing loss.

The CCS MTP provides physical therapy and occupational therapy services to program eligible children in the public school setting. The local education agency provides the space and equipment for the MTU, and the county CCS program provides the administrative and clinical staff. ***/2013/The State Interagency Cooperative Agreement between the CDE and DHCS, CMS, CCS MTP, was revised last year by CCS. //2013//***

The CMS Liaison to CDE participates on the Improving Special Education Services Stakeholders Group to achieve objectives of the State Improvement Grant.

MCAH is a part of the ASHWG collaborative comprised of representatives from CDPH, CDE and non-governmental organizations to address sexual and reproductive health issues of California adolescents.

MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children. In addition, The ECCS Coordinator is working with CDE on two early childhood grants: 1) to train early childhood child care and educators on evidence-based practices for identifying and working with autistic children in their environments, and 2) to train the trainers at pilot sites to work with early childhood care and education staff on how to promote the social emotional wellness of young children. The goal is to create a statewide, sustainable system that is based on a common approach developed by Vanderbilt University Center on the Social Emotional Foundations for Early Learning.
> Department of Developmental Services (DDS)

CCS and Medi-Cal provide medical services to eligible infants and toddlers receiving services through the Early Start Program. Through participation on the Interagency Coordinating Council and Health Services Committee, CMS maintains ongoing communication with DDS. Some CCS clients also receive Regional Center Services and care coordination between CCS and DDS.

CMS executed a Data Use Agreement with DDS to obtain outcome data on Early Start program enrollment of infants identified with hearing loss through the Newborn Hearing Screening Program.

MCAH collaborates with the Early Start program at DDS on planning and implementation activities of the ECCS grant. The ECCS coordinator has been appointed by Dr. Mark Horton, to represent CDPH on the DDS Early Start Interagency Coordinating Council, as mandated by the Individuals with Disabilities Education Act. CDPH also participates on the Data Committee.

DDS has expressed interest in the potential for prevention through MCAH preconception health activities and invited to participate on the PHCC.

> Department of Social Services (DSS)/Children in Foster Care
HCPCFC is a collaboration between DSS and CMS to improve oversight of health care for children in foster care. CMS initiated a performance measure to evaluate the effectiveness of the HCPCFC administrative case management. A data collection system is being developed. ***//2013//Revised performance measures will be implemented on July 1, 2013.//2013//***
With the passage of AB X4 4 in July of 2009, the HCPCFC became a mandated program statewide. The role of the Public Health Nurse (PHN) remains that of administrative case manager working collaboratively with the Social Worker and/or Probation Officer.

Five regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis. ***/2013/Four regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis. //2013//***

AFLP continues to collaborate with the DSS/CalLearn as part of case management oversight for pregnant and parenting teens.

Under the ECCS grant, the Statewide Screening Collaborative (SSC) continues to provide technical assistance to DSS to implement developmental screening at the county level for foster children as part of the federal law, Child Abuse Prevention and Treatment Act, which requires that any child under the age of 2 with substantiated abuse or neglect be referred to early intervention services.

/2012/Assembly Bill 12 (AB 12), California's Fostering Connections Act was signed into law on September 30, 2010 bringing numerous changes to the Foster Care system, most notable the extension of foster care benefits to age 21. //2012// ***/2013/CMS continues to collaborate with DSS and local program PHNs in the development of AB 12 related policies and procedures.//2013//***

> Managed Risk Medical Insurance Board (MRMIB)
CMS and MRMIB coordinate quarterly meetings throughout the state for medical plans, and separate meetings for dental plans. Ad hoc subcommittees comprised of members from CCS and MRMIB work together to train providers and resolve program issues.

Under ECCS grant, the SCC is working with MRMIB to identify ways to incentivize the use of standardized developmental screening tools in their plans. A survey was conducted in 2009 that showed only 1.26% of their children under the age of 5 were being screened with a validated tool.

> Childhood Lead Poisoning Prevention Branch (CLPP)

CMS, through CHDP, provides lead screenings for children. The CCS program covers the cost of evaluation and treatment of serious lead poisoning cases. The CHDP program and CLPP developed new approaches to screening that consider all low income children to be at risk and require blood lead screening.

The Health Assessment Guidelines section on management of elevated blood lead levels has been revised as recommended in the November 2007 Morbidity and Mortality Weekly Report.

CHDP and CLPP released a joint letter in December 2008 outlining the updated CDC recommendations on childhood lead poisoning prevention. /2012/CHDP and CLPP are reviewing blood lead referral and screening rates to ensure that blood lead testing is done at the appropriate intervals of 12 and 24 months.//2012//

MCAH and CMS participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning and meet the HP 2010 goal. A federal interagency strategy and objectives have been developed. /2012/MCAH is no longer involved in this project.//2012//

> Immunization Branch (IZB)
The CMS and IZ Branches collaborate with the Vaccines for Children (VFC) program by providing vaccination coverage and modifications through the CHDP program, including: tetanus, diphtheria and acellular pertussis vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, hepatitis B, Haemophilus influenzae type B vaccine, rotavirus, influenza, human papillomavirus and meningitis vaccines.***/2013/Pneumococcal vaccine (PCV13 and Pneumovax23 when appropriate) are provided by the CHDP program.//2013//***

CMS and IZ Branches, Medi-Cal, and MCMC meet three times per year to discuss results of the Advisory Committee on Immunization Practices (ACIP)-VFC National Meetings. CMS and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH has partnered with the IZ Branch to provide immunization updates to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy and the importance of influenza vaccination. /2012/MCAH worked closely with the IZ Branch to provide information on pertussis to MCAH providers.//2012//

> California Nutrition, Physical Activity and Obesity Prevention Program/ Champions for Change
MCAH and CMS collaborate with the California Nutrition, Physical Activity and Obesity Prevention Program and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity. MCAH and CMS participated on the 2009 Childhood Obesity Conference committee, which showcased evidence-based prevention interventions and community efforts. MCAH featured their BBC project, working with hospitals to integrate Quality Improvement efforts within the maternity care setting to ensure policies and practices are supportive of breastfeeding, as well as the work they are doing to promote healthy weight before, during and after pregnancy, and "Tracking Childhood Obesity Trends Using Geographic Information System (GIS) Mapping, California: 1996-2006." MCAH was also on the planning committee for the 2009 Weight of the Nation, a national forum to highlight progress in the prevention and control of obesity through policy and environmental strategies. MCAH was instrumental in including a life course perspective and a presentation on BBC.

/2012/MCAH is working on the next Childhood Obesity Conference scheduled for 2011 in San Diego, partnering with CDE, UC Berkeley's Atkins Center for Weight and Health, CA Endowment and Kaiser Permanente.

MCAH participated in a multi-agency workgroup to develop the Health in All Policies Task Force report which has specific nutrition and physical activity recommended policies, programs, and

strategies that State agencies can implement to advance health.

PHCC Interconception Care Project of CA, in coordination with ACOG District IX and funded by MOD, is finishing provider guidelines for the post-partum visit, which include management of women who developed gestational diabetes during their prior pregnancy.//2012//

> Medi-Cal Managed Care Division (MCMC)
California WIC Association, WIC, and MCAH meet monthly with MCMC Division to clarify and simplify access to breastfeeding supportive benefits.

> Safe and Active Communities Branch (SAC)
The Safe and Active Communities (SAC) Branch is the lead agency within CDPH responsible for coordinating statewide injury and violence prevention efforts. This includes the prevention of intentional and unintentional injuries as well as surveillance and epidemiology. Current intervention efforts focus on child passenger safety (CPS), violence prevention (ranging from child maltreatment, violence against women, including sexual assaults, homicide and suicide), elder maltreatment, fall prevention, pedestrian safety and creating safe and active communities conducive to walking and bicycling. SAC's injury surveillance and epidemiology program includes the California Injury Data Online, a web-based do-it-yourself injury surveillance table builder (www.dhs.ca.gov/EPICenter).

MCAH collaborates with SAC on injury prevention activities, including local training programs, SIDS and the Child Death Review Team (CDRT), SAFE-KIDS California Advisory Committee and the Strategic Coalition on Traffic Safety. MCAH Title V support data collection and prevention work of the local CDRTs. MCAH and SAC are also working together to address Electronic Death Recording System data issues related to Shaken Baby Syndrome and SIDS. ***/2013/MCAH and SAC will also be collaborating to analyze trauma related maternal deaths.//2013//***

> Office of Audits and Investigations
MCAH works closely with DHCS Audits and Investigations to ensure the integrity of MCAH programs.

> Genetic Disease Screening Program (GDSP)
CMS and GDSP work together to address issues as they arise and update policies and reporting /forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

CCS provides services for conditions identified on (NBS) tests, develops standards, and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) for treatment.

/2012/MCAH collaborated with GDSP to revise "Your Future Together," a preconception and prenatal health information booklet for women obtaining marriage licenses.//2012//
/2013/Newborns screening now also includes screening for Severe Combined Immunodeficiency. //2013//

> Women, Infants & Children (WIC) Supplemental Nutrition Division
MCAH and CMS collaborate with WIC in a variety of areas, including improvement of prenatal care, linkages between MCAH and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding. In 2010, MCAH began collaborating with WIC on several applied, public health research projects (as described in Section III-A).

MCAH collaborated with WIC on updating WIC food packages to ensure foods address the nutritional needs of women, infants and children and are consistent with the 2005 Dietary Guidelines for Americans. The modifications enhance the nutritional quality of foods available to WIC families, improve health outcomes, and expand the cultural food options and overall food

choices for WIC's diverse populations. CMS also collaborated on the regulations for medical providers. MCAH partnered with WIC to facilitate diffusion of the new information.

WIC, MCAH, California WIC Association, and the Nutrition, Physical Activity and Obesity Prevention Program developed a California Breastfeeding Roundtable to develop and implement a breastfeeding strategic plan.

CMS collaborates with WIC regarding CHDP provider relations, relevant health assessment guidelines and communications. For example, WIC's food package changes and the new pediatric referral form were communicated to CHDP providers via Provider Information Notices. CHDP Health Assessment Guidelines promote the use of WIC nutrition education materials for providers to use for anticipatory guidance. Additionally, CMS assists WIC with using the Pediatric Nutrition Surveillance System (PedNSS) prevalence data for local program nutrition education plans.

CMS also coordinates with WIC regarding the provision of specialty enteral nutrition products for the Special Needs Population in WIC and CCS.

CMS, WIC and MCAH meet quarterly for program updates /2012/ coordinate projects and develop relevant policies/guidelines.

MCAH coordinated with WIC, CA WIC Association, the CA Obesity Grant and the CA Breastfeeding Coalition to coordinate National Breastfeeding Week activities, and hosted the 2011 Hospital Breastfeeding Summit. MCAH also partnered with WIC to develop and disseminate a teen cookbook.//2012// ***/2013/This collaboration continued for the 2012 2nd Annual Breastfeeding Summit.***

CDPH Center for Health Care Quality
Collaboration between CDPH and CMS: CLABSI reporting. CDPH issued its first public report on hospital CLABSI in 2012. CMS and CDPH have begun to collaborate to help ensure benchmarking data accuracy because neonatal reporting entails data elements unique to this age group and evaluation of inconsistent/anomalous values requires specialized knowledge of NICU care processes.//2013//

> Universities
MCAH and CMS work closely with the University of California and other universities in the state. Partnerships include the National Adolescent Health Information Center and the Bixby Center for Reproductive Health Research & Policy at UCSF, Stanford University (on CMQCC and CPQCC issues), and the Center for Injury Prevention Policy and Practice at San Diego State University (SDSU). UCSF FHOP provides consultation and training to local MCAH jurisdictions in monitoring and updating local 5-year plans, data collection, identification of data sources, data analysis and survey development. FHOP also provides consultation, data analysis, stakeholder meetings and interviews for the Title V Needs Assessment. In collaboration with MCAH, UCSF Center on Social Disparities in Health conducts, analyzes, and reports on MIHA.

UCLA's Center for Healthy Children, Families and Communities participates in the Statewide Screening Collaborative as well as collaborate with the maternal QI project. /2012/ UCLA was contracted to conduct an analysis of maternal morbidity and improve data collection at hospitals that is needed to report on Joint Commission obstetrical measures for quality improvement.//2012// ***/2013/Additionally, the UCLA Center for Health Policy Research has been contracted to provide the 1115 Bridge to Reform Evaluation, as well as the evaluation of the Pediatric Palliative Care Waiver Program.//2013//***

MCAH provides MPH student internships, and mentoring for students and physicians in training.

MCAH contracted with the UCSF Center on Social Disparities in Health to assess BIH program services. UCSF's recommendations have served as a foundation to develop a standardized intervention and evaluation plan. /2012/UCSF partners with MCAH in the development and implementation of the evaluation of BIH.//2012//

Through a contract with SDSU Institute of Public Health and CCHA the Catheter Associated Bloodstream Infection Prevention Neonatal Quality Improvement Initiative (NQI) using the IHI model was initiated in 2007 with 13 regional NICUs. CLABSIs were reduced by 29% in all weight groups. The collaborative expanded in 2008 to include all 22 CCS-approved regional NICUs. And in July 2009, the collaborative has continued on with 14 regional NICUs and expansion to all hospital associated bloodstream infections. /2012/The bloodstream infection (BSI) prevention Collaborative is continuing through 2012.//2012//

> California District of the American Academy of Pediatrics (AAP-CA)
Under the leadership of MCAH ECCS, the SSC is working with the AAP-CA. AAP-CA has designated Dr. Renee Wachtel, a developmental pediatrician, to represent the AAP-CA on the SSC. She has been leading a subcommittee for the Collaborative to work with Medi-Cal Fee-For-Service on identifying issues with developmental screening reimbursement. Recommendations to be provided to Medi-Cal in spring 2010.

/2013/ Conference calls between the AAP-CA Chapter Champions, the state NHSP staff, and the HCC directors occur every other month. An article on the NHSP was published in the District magazine. A podcast is being developed to educate pediatricians about the NHSP and their role in coordinating care during and after the identification process. Two of the Chapter Champions will be attending the national Early Hearing Detection and Intervention meeting in 2012. No Chapter Champion from Chapter 3 has been designated//2013//

The CMS Branch collaborates with AAP-CA on many initiatives such as the 1115 Waiver, the CCS Needs Assessment, and the Palliative care Initiative.

/2012/> American Congress of Obstetricians & Gynecologists California (ACOG) District IX
ACOG supported the toolkit to eliminate non-medically indicated deliveries prior to 39 weeks gestation and developed a Speaker's Bureau for the statewide effort. ACOG has representation at PHCC and CMQCC Executive Committee.

>March of Dimes (MOD)
MCAH partners with MOD in the PHCC. MOD and ACOG with input of the Preconception Council is developing an Interconception Health Care Toolkit for use in California. MCAH provided a toolkit to eliminate non-medically indicated deliveries before 39 weeks gestation to the MOD for national dissemination. MOD funds 8 California obstetrical hospitals in a national collaborative to reduce elective early term deliveries. MOD provided CPeTS with a grant to develop regionalized, risk appropriate maternal care. MCAH previously collaborated with MOD on the Preterm Labor Assessment Toolkit and a Folic Acid Promotion Campaign. //2012// ***/2013/ MCAH will be collaborating with MOD as well as the Association of State and Territorial Health Officers to meet their national challenge to reduce preterm births by 8% from 2009 levels by 2014.//2013//***

> California Association of Neonatologists (CAN) and Stanford University
CMS and MCAH work with these groups on a perinatal and neonatal morbidity and mortality reporting system that provides information on quality of care, and serves as a basis for quality improvement in participating hospitals. CMS participates in CAN/District IX Board Meetings and annual conferences and in 2009-10 has provided progress reports on the Federal 1115 Waiver Renewal and the CCS Technical Workgroup which will be making recommendations for CCS redesign http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx. Collaboration with

Stanford and CPQCC continues with NICU and HRIF data collection and the breast milk nutrition QI Collaborative. CMS has worked with the Packard Foundation as they assess a service system for Children and Youth with Special Health Care Needs (CYSHCN) in CA. /2012/ CMS is working with CAN on NICU Z code conversions to national codes and looking at NICU models of provider reimbursement.//2012//

> Children's Specialty Care Coalition (CSCC)
CSCC is an organization of pediatric specialty and subspecialty providers practicing at CCS-approved tertiary hospitals and Special Care Centers. CSCC has participated in the Title V Needs Assessment process and is also an active participant in the 1115 Waiver Redesign process. /2012/CSCC is working with CCS and Medi-Cal on Z code conversions to national codes for NICUs and PICUs.//2012//

> California Conference of Local Health Officers (CCLHO)
CMS works with CCLHO on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system.

> California Children's Hospital Association (CCHA)
The Children's Hospitals are vital providers of services to children in the CCS program. CMS works closely with hospitals in the Title V Strategic Planning Process; develops quality improvement initiatives; and advocates for children's services.

In collaboration with CCHA, CMS is sponsoring a Neonatal Quality Improvement Initiative. CMS collaborates with CCHA in the NQI Initiative, which includes all 22 Regional NICUs. /2012/This collaboration ended in 2009.//2012//

> Other Professional Organizations
CMS collaborates with the California Dental Association, the California Association of Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, California Association of Ophthalmologists, California Association of Medical Products Suppliers and the Hemophilia Council and Foundations to improve working relationships, recruit providers, and address barriers to access to services. CMS works with Medi-Cal to improve reimburse processes for providers.

A number of professional organizations are actively involved in the Title V Needs Assessment process and participating in the 1115 Waiver Redesign process.

CMS collaborates with the Children's Hospice and Palliative Care Coalition to develop a federal Medicaid waiver to allow CCS clients to access ‘hospice-like' services while still receiving treatment services for their eligible conditions. There are 60 members of the stakeholder group providing input into the waiver design and development, including representatives from the Children's' Hospitals, University of California hospitals, CSCC, hospices and home health agencies.

The Palliative Care Waiver was approved by Federal Centers for Medicare and Medicaid Services with a start date of July 1, 2009. /2012/Start date was April1, 2009.//2012//

ECCS partners with many others through the SSC, including First 5, the California Academy of Family Physicians, the California Association of Health Plans, and the Advancement Project.

MCAH contracts with the CAHC to support LHJs' efforts on adolescent health.

MCAH collaborated with the Network for a Healthy California to develop a proposal for a preconception health social marketing campaign, funded by a HRSA/MCHB First Time Motherhood grant.

MCAH and CMS are involved in strategic planning for California's CDC-five year funded Nutrition, Physical Activity and Obesity Prevention Program. CMS conducted statewide webinars with local CHDP program staff to identify health care strategies for the health care sector of the Obesity Prevention Plan.

CMS coordinated with MCMC Health Plans: Kaiser, Cal Optima, Anthem Blue Cross and Health Plan of San Joaquin to provide training workshops, "Pediatric Obesity: Provider Skill Sets for Improved Care" to accelerate provider practice changes regarding childhood obesity. CMS is collaborating with Head Start on childhood obesity intervention since the majority of Head Start children receive health assessments through CHDP.

/2012/MCAH collaborates with the ARC of CA in the Fetal Alcohol Spectrum Disorders Task Force ,an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives affected by FASD and eliminating alcohol use during pregnancy.

MCAH has representation on the US Breastfeeding Promotion Committee and on the MCH Nutrition Council of the Association of State and Territorial Public Health Nutrition Directors(ASTPHND). The Council addresses policy, programs and services including promoting nutrition wellbeing across the lifespan for women including breastfeeding. The MCAH Nutrition and Physical Activity Coordinator served as Chair of the ASTHPND MCH Nutrition Council. The Council's goal is to achieve optimal health through healthy eating and active living and provide members with networking, educational and advocacy opportunities.

CMS is coordinating with MCAH to present at the 6th Biennial Childhood Obesity Conference during the Healthcare Prevention Strategies Track. The workshop will address the efforts made by the CHDP program related to pediatric obesity. Also, CMS is collaborating with MCAH and WIC to develop strategies to implement the new WHO Growth Charts. The CHDP Nutrition Subcommittee has been charged with the task of developing CHDP provider trainings on the use of the new WHO Growth Charts.

>Multiple Collaborations through Home Visiting Program
MCAH joined with DSS, ADP, and CA Head Start State Collaboration Office of CDE to develop the state's Home Visiting Program application and Needs Assessment.

Additional input was obtained from the CA Emergency Management Agency; the Safe and Active Communities Branch of the CDPH; the STOP Violence Against Women regional coordinator for CA; CA Partnership to End Domestic Violence; and the Domestic Violence Assistance Program and local MCAH directors /2012//

F. Health Systems Capacity Indicators

Introduction

Social, demographic and economic factors have been identified to explain the disparities in health. Some argue that health disparities may reflect the variation in health system characteristics such as the adequacy of public health services and the availability and quality of health care services received.

This section covers a discussion of select health indicators, a comparison of health disparities with programs targeting the economically disadvantaged populations and public health activities that aim to close the disparity gap. Please note that in California, the Medicaid Program is called Medi-Cal; SCHIP is called HF; EPSDT is called the CHDP Program.
>Asthma Indicator

HSCI 01 is the rate per 10,000 for asthma hospitalizations among children less than five years old. The rate of children hospitalized for asthma decreased from 22.9 per 10,000 in 2009 to 22.3 per 10,000 in 2010. The HP 2020 target for asthma hospitalizations for children less than five is 18.1 per 10,000 population; this rate was achieved for Whites . . Hospitalization rates for asthma were highest among African American children (54.0 per 10,000) compared to Hispanics and Whites (21.1 per 10,000 and 18.1 per 10,000, respectively).

Efforts to address childhood asthma are guided by the California Asthma Public Health Initiative (CAPHI), which is implemented by the CCDPHP in CDPH. CAPHI seeks to reduce preventable asthma morbidity and mortality; to eliminate disparities in asthma practices and outcomes; and to implement effective programs and policies in asthma education, management, and prevention according to the National Asthma Education and Prevention Program Guidelines.

CAPHI and CDPH spearhead the Enhancing Local Capacity to Address Asthma Priorities (ELCAAP) Program. The purpose of the ELCAAP Program is to work directly with six California county health departments (Fresno, Kern, Kings, Madera, Stanislaus and Tulare) collaboratively facilitate local efforts to reduce the burden of asthma in the 5 key goal areas identified in the Strategic Plan for Asthma in California (2008-2012). These areas include: awareness and infrastructure, data/surveillance, health care, indoor environments, and outdoor environments.

Kings County local MCAH priority is to collaborate with their local asthma coalition to develop and implement one strategy to provide educational outreach about appropriate asthma management to parents and children with asthma in relation to the effect of 2nd and 3rd hand smoke.

>Perinatal Indicators for Medicaid and non-Medicaid Population

HSCI 5a to HSCI 5d compares Medicaid and non-Medicaid perinatal indicators. Payment source data are obtained from birth certificates. Non-Medi-Cal payment sources include private insurance, self-pay, no charge, other government programs and medically indigent.

HSCI 5a compares Medicaid and non-Medicaid in the percent of low birth weight (<2,500 grams, LBW) babies. HSCI 5a remained at 6.7 percent for Medicaid clients and 6.8 percent for non-Medicaid clients in 2010. African Americans covered by Medicaid had a rate of 13.0 percent compared to 11.1 percent among those not covered by Medicaid.

HSCI-5b compares Medi-Cal and nonMedi-Cal infant death rates. The infant death rate was higher among Medi-Cal births (5.5 per 1,000) than among non-Medi-Cal births (4.2 per 1,000) in 2009. The infant death rate decreased for Medi-Cal births and non-Medi-Cal births in 2009. The non-Medi-Cal births achieved the Healthy People 2010 goal of 4.5 infant deaths per 1,000 in 2009.
The disparity by payor was most apparent for Whites, for whom the infant death rate was much higher for Medi-Cal (6.0 per 1,000) than for non-Medi-Cal (3.5 per 1,000) births in 2009. Infant death rates at 11.1 per 1000 were highest for MediCal births among African Americans. Infant death rates for non-Medi-Cal African Americans were at 8.3 per 1,000.

Health Systems Capacity Indicator 05c (HSCI-05c) compares the number of Medi-Cal and non-Medi-Cal pregnant women receiving first trimester prenatal care. After a decline between 2005 and 2008, HSCI 5c has increased the past two years, reaching 83.5 percent in 2010. The percent of women entering prenatal care in the first trimester was lower for Medi-Cal births (77.5) than for non-Medi-Cal births (88.9%) in 2010. This difference was noted for all race/ethnic groups.

Health Systems Capacity Indicator 05d (HSCI-5d) compares Medi-Cal and non-Medi-Cal on the percent of women with adequate prenatal care (Kotelchuck Index). This index considers the mother's timing of initiation of prenatal care and the number of prenatal care visits recommended

by ACOG. In 2010, 76.6 percent of Medi-Cal women had adequate prenatal care, a slight increase from 76.4 percent in 2009. In comparison, 82.3 percent of non-Medi-Cal women had adequate prenatal care

HSCI4 duplicates what is already reported for HSCI 5d, the percent of women ages 15 to 44 with a live birth during the year whose observed to expected prenatal visits are at least 80 percent on the Kotelchuck Index. The percent for HSCI slightly decreased to 79.6 percent in 2010. Asian and White women had the highest percent at 82.8 and 82.6 percent, respectively, followed by Hispanics (78.0%), Multi-Race (77.6%), African Americans (74.2%), and Pacific Islanders (65.8 percent. AIs had the lowest rate at 65.7 percent.

MediCal clients have lower rates of early entry into prenatal care or the number of prenatal care visits and have a higher infant mortality rate. Despite this disparity, MediCal has helped narrow the gap in access to care faced by those without insurance and promoted broader use of preventive and primary care services. As the workhorse of California's healthcare system for those left out of private health insurance, it provides coverage of the low-income population who tend to be sicker, poorer, a minority, unmarried, has less than high school education and has a health condition that limits work compared to the privately insured low-income population. [36] Attempting to address the disparity in the current economic climate is even more challenging. As MediCal rates are cut further, more providers are turning down MediCal beneficiaries or leaving the program making it even more difficult to access qualified providers. Multiple lawsuits have been filed to stop scheduled reductions in MediCal payment rates, reflecting the generally low reimbursement rates in California. For example, California ranks 47th lowest physician payment rate among the 50 Medicaid programs in 2008. [37] Although not yet approved by the federal Medicaid program, Legislature imposed MediCal copayments as part of the 2011-12 state budget agreement. Enrollees will potentially face copayments ranging from $3 to $100 for prescription drugs, hospitalization, and other services in 2012. Research shows that low-income individuals who are charged more for health care tend to reduce their use of essential health services. [38]

For women with a health insurance but no maternity coverage, two bills were chaptered that would require maternity coverage to be included in comprehensive health insurance policies by July 2012. SB 222 would apply to the market for individual policies, and AB 210 would apply to small group health plans. This relieves pregnant women from choosing between paying for maternity care herself, seeking help from a state program for low-income women or choosing from a small number of plans with comparatively expensive maternity coverage.

AFLP and BIH continue to assist low-income women by promoting the importance of accessing prenatal care and assist and refer clients to enter into care as early in their pregnancy as possible. Additionally, program case managers follow-up to ensure they are continuing to receive prenatal care throughout their pregnancy.

CPSP offers a comprehensive prenatal care, which includes obstetrics, nutrition, health education, and psychosocial support. CPSP providers receive a financial incentive to initiate prenatal care in the first trimester of pregnancy.

MCAH LHJs partner with prenatal care providers in their community to assist women to access early, quality prenatal care. MCAH also promotes preconception and interconception care as part of the continuum of care for women of reproductive age.

MCAH works to decrease the incidence of LBW infants by providing at-risk women with comprehensive services including prenatal care, education, and psychosocial support. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born with LBW in California. BIH identifies at-risk pregnant and parenting African American women and assists them in accessing appropriate health care and supportive services.

MCAH and CMS collaborate with CPQCC on performance improvement in perinatal outcomes. RPPC supports implementation of clinical quality improvement strategies by collaborating with providers to address evidence-based quality improvement projects and improve risk-appropriate care.

MCAH participates in PHCC, providing information and resources to communities on achieving optimal health for women prior to pregnancy. Both participate in the Premature Infant Health Coalition to reduce premature births and improve outcomes for children born prematurely. CDRTs make recommendations on ways to prevent infant deaths. SAC Branch has completed CDRT trainings to promote the recruitment of injury prevention specialists. The Safe Surrender Baby Law and remedies for unsafe sleeping environments have been emphasized by CDRTs.

MCAH, the CDPH lead in reducing infant mortality, developed an action plan to address the infant mortality disparities.

Sixteen LHJs implement the national FIMR model. In Contra Costa, preconception education is integrated into the maternal interview, an essential component of the FIMR data-gathering process. Given its size, L.A. County uses a survey tool to conduct FIMR. Survey questions focus on maternal behaviors and health system variables that can be addressed by public health interventions.

Consistent with the Life Course Perspective, which emphasizes the importance of maximizing healthy living prior to and between pregnancies in addition to the life-long consequences of risks and poor health conditions, several LHJs implement programs to improve awareness of preconception and interconception health.

Unintended pregnancies are associated with lower rates of first trimester prenatal care utilization. [39] One of the goals of PHCC is to address unintended pregnancy by encouraging RLP.

>Eligibility and Access to Care for Medicaid and EPSDT Population Indicators

Eligibility requirements by MediCal and SCHIP for children and pregnant women remained stable. Health Systems Capacity Indicator 06a (HSCI-6a) compares the income eligibility requirements for Medicaid and the SCHIP for infants (ages 0 to 1). Infants were eligible for Medi-Cal if the family income was at or below 200 percent of the FPL. Infants were eligible for HF if the family income was between 200 and 250 percent of FPL.

Infants up to one year old born to women with family incomes between 200 and 300 percent of FPL and who were enrolled in AIM were eligible for 2 years in the AIM Program, provided the infant was not enrolled in no-cost Medi-Cal or employer-sponsored health insurance.

Health Systems Capacity Indicator 06b (HSCI-06b) compares the income eligibility requirements for Medicaid (Medi-Cal) and SCHIP for children from 1 year up to age 19. Children aged 1-5 years were eligible for Medi-Cal if the family income was at or below 133 percent of FPL; for children age 6-18, the eligibility level was 100 percent of FPL. Children aged 1-5 were eligible for HF with family incomes between 133 and 250 percent of FPL, and children aged 6-18 were eligible for HF if the family income was between 100 and 250 percent of FPL. The California 2012/13 budget eliminates SCHIP (HF) transferring beneficiaries to Medi-Cal beginning January 2013. This will simplify coverage and eligibility for children and families, improve coverage through retroactive benefits, increased access to vaccines and expanded mental health coverage and eliminate premiums for lower income beneficiaries.

Health Systems Capacity Indicator 06c (HSCI-6c) compares the income eligibility requirements for Medicaid and SCHIP/HF for pregnant women. Pregnant women are eligible for Medi-Cal with a family income at or below 200 percent of the FPL. Pregnant women with family income levels between 200 and 300 percent of the FPL are eligible for the AIM Program.

Health Systems Capacity Indicator 07a (HSCI-7a) is the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. For 2010, it is estimated that 93.4% of Medicaid eligible children received a service paid for by the Medicaid Program.

Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development. For FY 09-10, the annual indicator is 50%. One of the most important steps a state can take to provide health coverage to its children is to reach uninsured children who already qualify for Medicaid or the SCHIP. For 2010, it is estimated that 38.4% of California children were covered by MediCal or HF; among low-income children, the rate was 64.8% [40]

Despite the slight decrease in the percent of potentially Medicaid-eligible children who have received a service paid by MediCal (HSCI 7a) in 2010 compared to 2009, a study conducted by Georgetown University's Health Policy Institute found that the number of uninsured California children decreased significantly in recent years, largely because Medical started covering more kids who otherwise would have remained uninsured. Using the American Community Survey data for 2008 to 2010, the study found that California's uninsured children decreased by 11% to about 931,000, making it the third largest decline in uninsured kids over the two-year period [41] across states despite that more and more Californians lost their private coverage due to cost or they lost their jobs in the economic downturn and many more children found themselves living in poverty. This has significant impact nationally as 12.5% of the estimated 74 million children in the U.S. live in California.

California has made a strong commitment to reducing the number of uninsured children and ensuring access to healthcare services. Activities have included:

1) Support of streamlined Medi-Cal eligibility processes that encourage continuous coverage.

2) Support for LHJ MCAH programs, which screen and assess children for Medi-Cal eligibility and assist them to obtain needed services. LHJ MCAH programs also identify pregnant women and refer them to appropriate programs such as CPSP, AFLP and BIH. Several LHJ MCAH programs have local initiatives that assist families with uninsured children to enroll in government funded health insurance programs or pay for health insurance costs for children who are not eligible for government funded programs. The San Diego Kids Health Assurance Network Community Collaborative assisted the local Medi-Cal program in the development of educational materials to inform Medi-Cal eligible clients about the new citizenship verification requirements for Medi-Cal enrollment. Additionally, LHJs perform a wide variety of community outreach activities in multiple venues to facilitate enrollment in Medi-Cal and educate target populations about Medi-Cal services.

3) Public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning, well child care, prenatal care, childhood immunizations, and dental care.

4) Facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

5) Recruit, retain, and educate providers about the CHDP program, Gateway, and preventive services for children from families at or below 200 % of FPL. The CHDP Provider Manual is available online to assist providers with programmatic issues and day-to-day activities and provide statewide standardization of CHDP provider requirements for program participation. Local CHDP programs and their health departments assist children and their families to access preventive health examinations through health fairs, and interagency agreements with WIC and

Head Start. Local CHDP staff may also participate in community Advisory Boards.

The CHDP Health Assessment Guidelines for CHDP providers are under revision to include methods to provide FCC and culturally competent care. There will be continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive periodic preventive exams. Sections of the CHDP Health Assessment Guidelines include updated recommendations from AAP, Advisory Committee on Immunization Practices and CDPH.

With regard to EPSDT dental services, he CHDP Gateway covers dental services for pre-enrolled children up to 60 days after a CHDP health assessment and has increased access to dental services. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal or HF which includes dental benefits. Most Denti-Cal providers accept the pre-enrollment receipts and many children receive dental services through the Gateway.

CHDP tools such as the revised two-sided full color "PM 160 Dental Guide" will continue to improve the quality of dental screenings and more acceptable annual referrals to a dentist beginning at age one. A provider notice, under development, will encourage CHDP providers to discuss the importance of dental sealants with families of 6 and 12 year old children. Fluoride varnish applications (3/year) became a benefit of the Medi-Cal program. CHDP providers were informed of this benefit, asked to apply fluoride varnish, and be reimbursed through Medi-Cal.

Brochures entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" and "Every Child Needs a Dental Home" have been released to local CHDP programs and available online in three languages. A resource guide has been developed and distributed to local programs. It includes online links for brochures including most oral health topics for children ages 0 through 5 and 6 through 20. A Power Point training is being developed for CHDP Providers and local program staff which includes resources and oral health topics specific to screening and referring children to a dentist by age one. This training is expected to be placed on the CMS website. The Growing Up Healthy brochures with age specific dental information have been completed in 4 languages and are on the CMS Branch website

The State Dental Hygienist Consultant in conjunction with the Dental Subcommittee of the CHDP Executive Committee continues dental updates to providers, local program staff, and families. The dental sections of the Health Assessment Guidelines, including anticipatory guidance, are being aligned with Bright Futures Oral Health. Changes specific to California are being added.

>Rehabilitative Services for CSCHN Indicator

Health Systems Capacity Indicator 08 (HSCI-8) is the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. HSCI-8 is 30.4 percent for FY 2009-10 ; 30.1 percent for FY 2008-09 and 28.2 percent in the previous year. The numerator, 30,123 for FY 2009-10; 20,907 for FY 2008-09 and 25,534 FY 2007-08), is the number of open CCS cases under 16 years of age with aid codes of 20 and 60. The denominator, 95,788 for FY 2009-10; 93,899 for FY 2008-09 and 90,464 for FY 2007-08, is the percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

There have been several changes in how this indicator has been calculated over the last few years. The current methodology is as follows. The numerator is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving MTP services. The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current FY, for children under 16 years of age.

The CCS MTP provides physical therapy, occupational therapy, and Medical Therapy Conference (MTC) services to children who meet specific medical eligibility criteria. The majority of children have cerebral palsy. The children eligible for the MTP do not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. Services are provided in a Medical Therapy Unit (MTU), an outpatient clinic setting that is located on a public school site. Coordination of services in the MTU is under the medical management of a physician/therapy team.

MTU Online is a separate web-based software program for clinical documentation of MTU services. Twenty one counties are actively using MTU Online as of January 2009. This software allows for single entry of clinical data and narrative description by occupational and physical therapists and Medical Therapy Conference physicians.

Statewide clinical data is collected annually for MTP program management. The Functional Improvement Score (FISC) is used to measure the amount of functional change that a child achieves in a 6-12 month. The Neuromotor Impairment Severity Scale (NISS) measures the amount of neuromotor impairment for children with cerebral palsy or similar upper motor neuron conditions. Data analysis is limited due to budget cuts and it is projected that it will take several years to develop meaningful baselines and targets for program management.

The MTP module has moved to the web as of March 27, 2010. This web based administrative module is used to search, track, enter, modify, and report administrative data related to MTP.

Several county CCS programs utilize a new service care model that increases family responsibility in the child's therapy and its implementation. Data is currently being gathered to measure the effectiveness and outcomes of this service delivery model including FISC data.

>Data Systems and Data Access Indicators

MCAH has access to linked birth statistical master files (BSMF) and death statistical master files (DSMF) used for surveillance and program evaluation . The Perinatal Profiles report provides annual perinatal data analyses to hospitals annually. MCAH has access to patient discharge data (PDD) that contain information on population demographics, hospital/clinic characteristics, payer source, births and other conditions, procedures, and injuries. PDD is linked to both BSMF and DSMF. MCAH has access to BSMF linked with NBS data and birth defects registry data. MCAH also has access to Medi-Cal data. MCAH has linked BSMF and WIC prenatal services data.
In collaboration with UCSF, MCAH's MIHA is an annual survey of post-partum women modeled after CDC's PRAMS. Birth outcomes are provided through linkage with birth certificate data. Local data for the 20 largest California counties are available online.
CWHS, is an annual telephone survey that collect information on health insurance status, family planning, sexually transmitted infections, pregnancy, mental health, and lifestyle issues. MCAH sit on the CWHS advisory group, contribute questions to the survey, analyze data and present findings.
The California Health Interview Survey (CHIS), conducted by UCLA in collaboration with CDPH, DHCS, and PHI, is a bi-annual telephone survey of adults, adolescents, and children that collect information on health insurance coverage, health behaviors, chronic disease, mental health, oral health, and lifestyle issues. MCAH sit on the CHIS Technical Advisory Group.,
MCAH also collects data on its various programs, including AFLP, BIH, CDAPP, CPSP, FIMR, Home Visiting and SIDS. Data elements cover client socio-demographic information and service access information.
The Office of Vital Records (OVR) and MCAH collaborate on providing trainings emphasizing the importance of hospital administration, nursing and birth clerks working together to accurately report birth data.
who report using tobacco products during the past month. California obtains data on adolescent tobacco use from multiple sources. These include the biennial California Youth Risk Behavior Survey (YRBS), the California Student Survey (CSS), the California Healthy Kids Survey (CHKS),

the California Student Tobacco Survey (CSTS) and CHIS.

YRBS was implemented statewide for the first time in spring 2009 in schools using a random sample of 9th through 12th graders. The YRBS was developed to monitor priority health risk behaviors that contribute to the leading causes of mortality, morbidity and social problems among adolescents. The survey is part of a surveillance effort conducted by CDPH, CDE and the PHI in cooperation with the CDC. The biennial sample size for this survey is approximately 1,500 surveys. California is working closely with CDC to improve the YRBS response rate.

CSS utilizes data from a voluntary, representative, randomly-selected biennial sample of schools and classrooms (seventh, ninth graders, and eleventh graders). CSS collects information on adolescent alcohol and other drug use patterns, including data on tobacco use (smoking), marijuana, and inhalants, along with physical activity, nutrition and eating habits, depression, and external and internal resilience enhancing assets. CSS allows for trend data analyses, and provides data on a range of health related behaviors comparable with the CHKS, which is a school level survey that is similar to YRBS.

CHIS is a telephone survey of adults, adolescents, and children from all parts of the state. The survey is conducted every two years. CHIS is the largest state health survey and one of the largest health surveys in the United States and is able to provide statewide and local level estimates on a number of health related issues, including adolescent tobacco use. MCAH sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing the data.

CDPH's Tobacco Control Program (CTCP) coordinates statewide tobacco control efforts and funds CSTS. CSTS is a large-scale, biennial, in-school student survey administered to middle (grades 6-8) and high school (grades 9-12) students. The survey includes questions about tobacco-use behavior, such as cigarette, smokeless, and menthol, exposure to tobacco prevention efforts, exposure to tobacco marketing, and beliefs about the health consequences of using tobacco products. The County and Statewide Archive of Tobacco Statistics web site aims to provide access to a wide variety of tobacco-control related information and statistics, including evaluation resources for local projects, publications, and local information on tobacco-related indicators, ranging from behavioral measures to local policies. Data can be viewed by type, county, or statewide level. The sources of data originate from the U.S. Census Bureau, California Tobacco Survey (CTS); CSTS; Cost of Smoking Report 1999; Database, and the California Smokers' Helpline.

The annual Youth Tobacco Purchase Survey uses random, onsite inspections at retail sites by minors 15 and 16 years old to monitor illegal sales to adolescents.

IV. Priorities, Performance and Program Activities

A. Background and Overview

California's Title V performance reporting will include a total of twenty five to twenty eight measures: eighteen national performances measures (NPM) mandated by HRSA and seven to ten additional measures chosen by the state. /2012/ Sensible performance measures help our partners and stakeholders understand what is important , establish expectations in measurable terms, collect data on progress, make decisions with the collected information and adjust course when necessary. //2012// The three SPM in this report include the following:

SPM 01: The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home; ***/2013/ This was revised to: The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.//2013//***

SPM 02: The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care; ***/2013/ This was inactivated and replaced by a newly created SPM 10.//2013//***

SPM 03: The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey;

The seven other state performance measures under consideration may include some of the measures reported in the 2006-2010 Five Year Needs Assessment. /2012/ The additional SPMs in this report include:

SPM 04: The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy

SPM 05: The percent of cesarean births among low risk women giving birth for the first time.

SPM 06: The percent of women of reproductive age who are obese.

SPM 07: The percent of women whose live birth occurred less than 24 months after a prior birth.

SPM 08: The percent of adolescents reporting a high level of school connectedness.

/2013/SPM 09: Low-income infant mortality rate.

SPM 10: The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2013//

Careful consideration of incorporating the life course approach was used in selecting the MCAH-specific SPMs. Beyond measuring disease risk or conditions, these new SPMs include protective factors, cut across critical periods of development over the life course and may influence the capacity of the population to reach its full developmental potential. The detail sheets (Form 16) further emphasizes the influence of these SPMs on health pathways or trajectories, its impact on individual health within and across generations and its impact at specific sensitive periods of development.

Selection criteria for SPMs included availability of accurate data available, sufficient sample size, consistent data collection methodology over time, comparability to national data or benchmarks, , relevance to program planning and monitoring, and stakeholder buy-in. //2012// Data on performance measures are included in two parts of this report - on the data forms and in the narrative.

The three priorities currently identified targeting the CSCHN population were a result of the needs assessment conducted by CMS. The 2011-2015 CMS Five-year Needs Assessment process identified several priorities with the top three priorities included as part of this report. Following key informant interviews, focus group discussions, online-surveys, review of the 2005 CMS Needs Assessment priorities, consultation with CMS Branch state staff, and data analysis, 13 CMS priorities were identified and ranked. Stakeholders individually used the weighted criteria they had developed together and a tool provided by FHOP to rate each of the priority objectives. The individual rating scores were then aggregated to rank the priority objectives. The top 3 CMS priorities are listed as 1 to 3 below.

All ten of California's priorities have one or more related national or state performance measures. /2012/For NPMs, new SPMs and outcome measures that will be monitored for the 2011 to 2015 period, several meetings were held to discuss objective setting processes and methods. This included assessing program-related activities that impact each measure,

/2012/ In addition, the relationship between the seven MCAH priority needs with health systems capacity indicators and health status indicators were included as MCAH moves toward incorporating the Social Determinants of Health and Life Course approach to its health planning and decision framework .incorporating knowledge of effective interventions, identifying time frames for objective setting and determining a value for each performance objective that is challenging yet realistic. MCAH conducted a literature search on target setting methods that have been used including the rationale for its use, the advantages and disadvantages for each method and what compromises should be made when there is no existing evidence, or if evidence is weak or its relevance is limited. After an extensive review of multiple target setting methods, MCAH identified a straightforward approach that would be transparent for partners. Following the lead set by Healthy People 2020 in establishing standardized 10% improvement objectives, MCAH established 5% improvement over the 2008-2009 aggregate rate as the standard for California Title V Objectives. To ensure appropriate objectives were set for Title V measures with rates that have fluctuated from year to year, a 10% improvement objective was selected if the measure met or exceeded the 5% improvement objective since 2000. Likewise, a 15% or a 20% improvement objective was selected for measures with fluctuating rates that exceeded the 10% or 15% improvement objectives since 2000. For those measures that demonstrate worsening trends, a 0% improvement objective was established (or maintenance of current rate). In this way, State and Local MCAH Programs and stakeholders have an easily identifiable and reasonably attainable objective to strive towards over the next five years for each measure. //2012//

B. State Priorities

The ten priorities for Title V activities in California and the associated performance measures and health indicators are:

>Priority 1: Modify the CCS program, with appropriate funding, to cover the whole child.
SPM 1 (new): The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system. ***/2013/ This was revised to: The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.//2013//***

SPM 3(new): The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.
NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.
NPM 6: Youth with special health care needs who received the services necessary to

make transition to all aspects of adult life.

>Priority 2: Expand the number of qualified providers of all types in the CCS program.
SPM 2 (new): The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care. ***/2013/ This was inactivated and replaced by SPM 10: The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2013//***

NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.
NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 3: CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.
SPM 3 (new): The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.
NPM 2: CSHCN whose family's partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.

>Priority 4: Improve maternal health by optimizing the health of girls and women across the life course.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
SPM 3 (old): The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days (frequent mental distress").
SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
SPM 8 (old): The percent of births resulting from an unintended pregnancy.
SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
SOM 1 (new): The pregnancy-related mortality rate per 100,000 live births.
HSI 5a: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia
HSI 5b: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.
HSI 9a (2): Percent in household headed by a single parent.
HSI 9a (3): Percent in TANF (Grant) families. //2012//

>Priority 5: Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.
NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
/2012/SPM 6 (new): The percent of women of reproductive age who are obese. //2012//

>Priority 6: Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.
NOM1: The maternal mortality rate per 100,000 live births.
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 5 (new): The percent of cesarean births among low risk women giving birth for the first time.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
SOM 1: The pregnancy-related mortality rate per 100,000 live births.
HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
HSCI 5c: Percent of women entering care in the first trimester: Payment source from birth certificate (Medicaid and non-Medicaid comparison).
HSCI 5d: Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care (Medicaid and non-Medicaid comparison).
HSCI 6c: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for pregnant women (Medicaid and SCHIP eligibility levels). //2012//

>Priority 7: Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
SPM 6 (old): The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
NOM 1: The infant mortality rate per 1,000 live births.
NOM 2: The ratio of the black infant mortality rate to the white infant mortality rate.
NOM 3: The neonatal mortality rate per 1,000 live births.
NOM 4: The post-neonatal mortality rate per 1,000 live births.
NOM 5: The perinatal mortality rate.
HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
HSCI 5a: Percent at low birth weight (<2,500 grams): Payment source from birth certificate (Medicaid and non-Medicaid comparison).
HSCI 5b: Infant deaths per 1,000 live births: matching data files (Medicaid and non-Medicaid comparison).
HSCI 5c: Percent of women entering care in the first trimester: Payment source from birth certificate (Medicaid and non-Medicaid comparison).
HSCI 5d: Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care (Medicaid and non-Medicaid comparison).

HSCI 6a: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1) (Medicaid and SCHIP eligibility levels).
HSI 1a: The percent of live births weighing less than 2,500 grams.
HSI 1b: The percent of live singleton births weighing less than 2,500 grams.
HSI 2a: The percent of live births weighing less than 1,500 grams.
HSI 2b: The percent of live singleton births weighing less than 1,500 grams. //2012//
/2013/ SPM 9 (new): Low income infant mortality rate.//2013//

>Priority 8: Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.
NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored NBS programs.
NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 13: Percent of children without health insurance.
NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
/2012/ NOM 6: The child death rate per 100,000 children aged 1-14.
HSCI 1: The rate per 10,000 for asthma hospitalizations among children less than five years old.
HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
HSCI 3:The percent of Children's Health Insurance Program (SCHIP) enrollees' age is less than one year during the reporting year who received at least on periodic screen.
HSCI 6a: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1) (Medicaid and SCHIP eligibility levels).
HSCI 6b: The percent of poverty for eligibility in the State's Medicaid SCHIP programs for children (age ranges: 1 through 5 and 6 to 19) (Medicaid and SCHIP eligibility levels).
HSCI 7a: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
HSCI 7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year.
HSI 3a: The death rate per 100,000 due to unintentional injuries among children aged 14 years & younger.
HSI 3b: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

HSI 4a: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
HSI 4b: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.
HSI 9a(2): Percent in household headed by a single parent.
HSI 9a(3): Percent in TANF (Grant) families //2012//

>Priority 9: Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
SPM 5 (old): The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.
SPM 9 (old): The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.
/2012/ SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
SPM 8 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
HSCI 6b: The percent of poverty for eligibility in the State's Medicaid SCHIP programs for children (age ranges: 1 through 5 and 6 to 19) (Medicaid and SCHIP eligibility levels).
HSCI 9b: Data Capacity - Adolescent Tobacco Use (data capacity information).
HSI 3c: The death rate per 100,000 from unintentional violence due to motor vehicle crashes among youth aged 15 through 24 years.
HSI 4c: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
HSI 5a: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
HSI 9a(9): Rate per 100,000 juvenile crime arrest
HSI 9a(10): Percent of high school drop-outs grades 9 through 12. //2012//

>Priority 10: Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.
NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored NBS programs.
NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 13: Percent of children without health insurance.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in

the first trimester.
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
HSCI 3: The percent of Children's Health Insurance Program (SCHIP) enrollees' age is less than one year during the reporting year who received at least on periodic screen.
HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
HSCI 5: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State (a) Percent of low birth weight (<2,500 grams), (c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester and (d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]
HSCI 6: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.
HSCI7a: The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program
HSCI 7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. //2012//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	99.5	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100
Numerator	609	607	574	561	
Denominator	609	607	574	561	
Data Source		Genetic Disease Screening Program, 2008	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
A manual indicator is reported for 2011 based on 2010

Notes - 2010
Newborn screening includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, , and pilot testing for severe combined immunodeficiency disorders (SCID). In 2010, one confirmed case of sickle cell disease died before completion of confirmatory testing.

The number or affected newborns receiving timely follow-up is the number of cases summed over all screened disorders. It is extremely rare for a newborn to be a case for more than one screened disorder.

Notes - 2009
Source: State of California, Department of Public Health, Genetic Disease Screening Program, 2009 Newborn Screening Records.

Newborn screening includes screening for the following conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, and non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis and biotidinase deficiency. In 2007, 47% of the screenings added cystic fibrosis and biotidinase deficiency.

The number of affected newborns receiving timely follow-up is the number of cases summed over all screened disorders. It is extremely rare for a newborn to be a case for more than one screened disorder.

a. Last Year's Accomplishments
In 2010, GDSP detected and confirmed almost 600 genetic and congenital abnormalities as a result of its NBS Program. California has effectively achieved universal coverage for NBS for genetic, metabolic and hematological disorders, with nearly 100 percent of newborns screened for all conditions for which screening was mandated.

All the conditions for which the NBS Program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are CCS-eligible. GDSP and CMS have been collaborating to ensure that infants identified with abnormal metabolic, endocrine, sickle cell, cystic fibrosis, or pilot severe combined immunodeficiency disorder (SCID) screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS-approved Special Care Centers (SCC) in the state. The county CCS programs expedite GDSP referrals, so that infants with suspected illness can be identified and treated promptly in order to maximize prevention of premature death or serious disabilities. The guidelines for diagnostic follow-up and treatment of the over 40 additional metabolic disorders and congenital adrenal hyperplasia are in place.

In 2011, the California Prenatal Screening Program expanded to allow 1st trimester specimens for Integrated Screening and will consist of all 4 types of screening tests:
-Patients who submit a blood specimen in the 2nd trimester (15 to 20 weeks): Quad Marker

Screening [AFP, hCG, uE3, and Inhibin]
-Patients who had CVS and submit a blood specimen in the 2nd trimester: Neural Tube Defect (NTD)/Sickle Cell Disease (SCD) Screening [Risk assessment for NTDs and SCD only]
-Patients that submit a blood specimen in the 1st trimester (10 to 13 weeks 6 days) and 2nd trimester (15 to 20 weeks): Serum Integrated Screening [Pregnancy Associated Plasma Protein and hCG in the first trimester, plus Quad Marker Screening in the second trimester] -Full Integrated Screening:
-Nuchal Translucency Ultrasound when the crown rump length is between 45-84 mm, combined with Serum Integrated Screening.

The pilot study for SCID began in August 2010 and was the first DNA-based test used by the state laboratory as a screening tool. Findings of the pilot study show that 86% of "classic" SCID cases are Hispanic. To date there are no Caucasians with classic SCID, only SCID variant . It also found 3 Chinese cases of SCID variant or non-SCID immune deficiency which was unexpected. Almost all false positives are due to DNA amplification failure which occurs almost exclusively from babies in the NICU.
The results from the pilot had received national and international acclaim for its success and in increasing the knowledge base for what was thought to be an extremely rare disorder. With the success of the pilot study, AB 395 was introduced in February 2011 which requires CDPH to expand statewide screening of newborns to include screening for severe combined immunodeficiency (SCID) and , insofar as it does not require additional costs, other T-cell lymphopenias detectable as a result of screening for SCID, and would make related changes. The bill became law (Chapter 461, Statutes of 2011).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. GDSP screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.			X	
2. GDSP ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.				X
3. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.			X	
4. GDSP and CMS collaborate to ensure that infants identified with abnormal screening results receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CMS and GDSP programs work together to address issues as they arise and update policies and reporting forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

GDSP, along with several other states, conducted a pilot study during 2010 -- 2011 to evaluate the feasibility of screening for Severe Combined Immunodeficiency Disorders (SCID). The Health and Human Services Secretary's Advisory Committee for Heritable Disorders in Newborns and Children (ACHDNC) had made a national recommendation to states to add SCID to the (NBS) panel.

CCS provides services for conditions identified on NBS tests, develops standards, and approves Metabolic, Endocrine, Sickle Cell, Cystic Fibrosis, and SCID SCCs for treatment.

c. Plan for the Coming Year

GDSP will continue to screen for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. GDSP ensures the quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, GeneHELP Resource Center and the Sickle cell Counselor Training and Certification Program).

SCID has become a regular part of the state's NBS program, with a legislated fee increase for testing and follow-up case management. Legislation has been introduced in 2012 (AB 1731 Block) for the use of pulse oximetry as a screening tool for Critical Congenital Heart Defects (CCHD). GDSP, CCS, and CBDMP are collaborating to discuss the best way to implement CCHD screening in California.

GDSP will continue to work collaboratively with state and local agencies, including CMS, CCS-approved SCCs, GDSP NBS Contract Liaisons and other NBS Program staff, local County CCS programs, and Area Service Center Project Directors and Medical Consultants to ensure that newborns identified with positive screening reports are quickly evaluated, diagnosed, and appropriately treated, and that families are informed and supported throughout the process.

GDSP will continue to administer and evaluate the 1st Trimester Prenatal Screening Program. CMS and GDSP will continue to work together to address issues as they arise and update literature as needed. Despite the decreased staff, CCS will attempt to expedite authorizations appropriate for diagnosis and treatment of babies with positive results from newborn screening NBS.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**510981**			
Reporting Year:	**2010**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received**

					Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	503469	98.5	226	19	19	100.0
Congenital Hypothyroidism (Classical)	503469	98.5	482	226	226	100.0
Galactosemia (Classical)	503469	98.5	95	5	5	100.0
Sickle Cell Disease	503469	98.5	55	51	51	100.0
Biotinidase Deficiency	503469	98.5	121	14	14	100.0
Cystic Fibrosis	503469	98.5	221	74	74	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	503469	98.5	820	22	22	100.0
Tandem Mass Spectrometry (MS/MS) screening for non-PKU inborn errors of metabolism	503469	98.5	2004	138	138	100.0
Severe Combined Immunodeficiency (SCID)	188800	36.9	31	12	12	100.0
HIV Oraquick	13380		8	27	12	44.4
HIV Enzyme	5703		0	8	7	87.5
Expanded Alpha Fetoprotein (Prenatal Screening)	353130		22137	967	967	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	52.5	52.5	47	47.5	48
Annual Indicator	46.6	46.6	46.6	46.6	61.8
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	48	48	48	48	48

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06..

Notes - 2009
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 02 is one of five measures (see also NPM 03, 04, 05, and 06) taken from the National Survey of CSHCN. Based on the 2005-2006 survey, 46.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

1)CSHCN stakeholder groups were included in the implementation of priorities selected through the Needs Assessment process.

2) FVCA was represented in the workgroups, hearings and other activities related to development of the new federal 1115 waiver, CCS redesign, and the State Title V Needs Assessment. FVCA

provided written and verbal input on the development of these programs and policies.

3) The CRISS-FCC Work Group met several times to share ideas and resources; plan and coordinate conferences, trainings and activities; and monitor and promote transition activities, parent liaison services, and medical home projects.

4) County CCS programs collaborated with agencies and families to plan conferences on family participation in the CCS program.

5) FVCA Council held monthly meetings to address parent and community involvement and monthly Brown Bag Lunch webinars statewide on issues affecting CYSHCN to professionals and family members.

6) FVCA's Youth Advisory Council met monthly via conference call and face-to-face every other month).

7) LAPSNC, collaborated with organizations and parent groups to plan meetings and conferences.

8) The CCS Workgroup, supported by LAPSNC, met bimonthly and includes representatives from public programs, hospitals, and parent organizations. Meeting agendas were framed around the 6 core measures for CSHCN. Active parent engagement and involvement was sought for all Workgroup activities.

9) CRISS was represented in the workgroups, hearings and other activities related to development of the new federal 1115 waiver, CCS redesign, and the State Title V Needs Assessment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CMS will broaden its stakeholder group which includes family partnership to identify state priorities through the 2010 Needs Assessment process.				X
2. FVCA and CMS are working together to enhance services for families of CYSHCN and involve families as partners in decision-making.			X	
3. The FCC Work Group of CRISS, comprised of 14 county programs, meets bimonthly to plan annual conferences, workshops, resource fairs, and address issues.				X
4. CCS programs are partnering with Family Resource Centers in their areas.		X		
5. CMS is partnering in the planning of annual educational FCC conferences (Northern and Southern California) for CCS administrators, medical, nurse and social work consultants, parent health liaison/leaders, and therapists.		X		
6. County CCS programs evaluate and report their family participation in their programs.				X
7. The FCC Work Group is providing TA for CCS administrators for hiring or contracting a parent liaison.				X
8. County agencies and families are collaborating to provide workshops, resource fairs, and conferences for families of CSHCN.		X		

9.				
10.				

b. Current Activities
1. FVCA participates in the Pilot Project Evaluation Oversight Committee.

2. FVCA youth advisory council continues to meet.

3) In April 2012, FVCA held its ninth statewide Health Summit in Sacramento, bringing together families, advocates, state agency representatives, health policy advocates, legislative representatives, providers and insurers. The Summit focused on identifying budget issues in California that significantly affect the health care of CSHCN and developing strategies to ensure that families in California are able to access family-centered, affordable care.

4) FVCA tracks emerging issues and statewide trends, the numbers of families and professionals provided with education, information or training, identifies solutions, and determines training needs.

5)FVCA continues to support and promote the use of CCS Parent Health Liaisons and other partnerships between community-based organizations and the state.

c. Plan for the Coming Year
1) Families included in stakeholder groups will continue to participate in activities to improve the delivery of care for CSHCN through the 1115 Waiver.

2) Family members will participate on advisory committees and in-service training of CCS staff and providers

3) FVCA will support and promote Parent Health Liaison (PHL) services and provide training materials to PHLs to assist families.

4) FVCA will continue to emerging issues and statewide trends, the number of families and professionals provided with information, education and support and the impact of family support services on families.

5) FVCA will continue to collaborate with CMS and respond to requests for input on materials and committees.

6) CMS medical director or designee will attend bimonthly FVCA webinars

7) FVCA's Youth Advisory Council will continue to meet bimonthly and implement their strategic plan (pending ongoing funding).

8). .CRISS convenes quarterly meetings of county CCS medical consultants, CRISS staff, and the CCS Chief Medical Officer in order to ensure consistent application of state CCS policy. Starting this year, the Southern California medical consultants are also meeting quarterly, and twice a year, consultants from northern California attend the southern California meeting and vice versa.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	51	51	42.5	43	44
Annual Indicator	42.2	42.2	42.2	42.2	38.3
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	44	44	44	44	44

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

Notes - 2009
This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions

and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

a. Last Year's Accomplishments
NPM 03 is from the National CSHCN Survey. Based on the 2005-2006 survey, 42.2 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The most recent National Survey of CSHCN (2005-2006) conducted by the Special Population Surveys Branch of the CDC- NCHS, identified approximately 750 parents of children with special needs in each state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with University of Southern California's UCEDD at Children's Hospital Los Angeles, CRISS, and FVCA, on Project Access to increase the number of medical homes for children with epilepsy in Sonoma County.		X		
2. County CCS programs assess CCS eligible children to determine if they have a documented medical home and explore improvement strategies				X
3. The "Hospital Discharge Questionnaire" developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital.				X
4. Child Health Notebooks to help organize healthcare information and medical records are distributed (also available electronically) in the 14 CRISS counties.				X
5. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
6. FVCA Agencies provide a "resource referral pads" to physicians that list local resources for families.				X
7.				
8.				
9.				
10.				

b. Current Activities
1) CRISS continues to expand and improve the Alameda County Medical Home Project. The project targets clinics in Alameda with high numbers of CCS children.

2) CRISS is distributing medical home materials in hard copy and electronically for the 11 new rural counties, including Fresno. All these materials also will be available on the CRISS website.

3) CRISS continues to distribute updated medical home materials and Child Health Notebooks to CRISS counties.

4) CRISS continues to distribute Child Health notebooks to the CRISS counties and are available electronically.

5) CRISS convenes quarterly meetings of county CCS medical consultants, CRISS staff, and the CCS Chief Medical Officer in order to ensure consistent application of state CCS policy. Starting this year, the Southern California medical consultants (LAPNC) are also meeting quarterly, and twice a year, consultants from CRISS attend the southern California meeting.

6) FVCA will continue to provide trainings for families and professionals on Medical Home and distribute binders to help families organize healthcare information and medical records.

7) FVCA Agencies will provide "resource referral pads" to physicians, listing local resources for families.

8) The Sonoma County FQHC continues its activities to promote medical homes for children with epilepsy.

c. Plan for the Coming Year

1. CRISS will continue to share Alameda County Medical Home Project activities and resources with 3 other counties, San Mateo, Contra Costa, San Francisco.
2. For counties not in a Pilot Project, CCS will continue to monitor number of CCS clients with a designated Medical Home.
3. CCS 1115 Waiver Pilot Projects will incorporate Medical Home into the comprehensive health care delivery system and will be one of the major areas of performance evaluation for the project.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	68.5	65.5	60	60.3	61
Annual Indicator	59.6	59.6	59.6	59.6	59.1
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	61	61	61	61	61

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2009
This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 04 is from the CSHCN Survey and is related to population-based services. For the 2009-2010 survey, 62.8 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed. The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified at least 750 parents of children with special needs in each state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMS Branch continues to determine whether CCS eligible children have access to private health coverage utilizing DHCS' Other Health Coverage (OHC) file.		X		
2. CHDP programs and providers are identifying and "deeming" certain infants less than one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP Health Assessment.		X		
3. CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.		X		

4. CMS Branch will continue to implement the CHDP Gateway and identify CCS-eligible children through the Gateway process.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) CMS continues to collaborate with various stakeholders in helping to ensure that families of CSHCN continue to receive necessary services.

2) The CHDP Gateway pre-enrollment process serves as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and CMS continues to support this process.

c. Plan for the Coming Year
1) CMS will continue collaborative efforts with various stakeholders to identify and provide necessary services for CSHCN.

2) The CHDP Gateway pre-enrollment process will continue to serve as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and the CMS Branch will continue to support this process.

3) CMS will continue to review the impact that Health Care Reform may have on families of CSHCN that are currently being served by CCS, AIM, HF and Medi-Cal.

4) As resources become available, CMS will continue to review initiatives that have the goal of promoting insurance coverage for children.

5) Through the 1115 Waiver's CCS pilot projects, infants, children, and youth with special health care needs will receive comprehensive care instead of care being fragmented.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	71	85.5	86	86.5	87
Annual Indicator	85.3	85.3	85.3	85.3	64.8
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	87	87	87	87	87

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2009
This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years who can easily access community based services. For California in 2009-2010, the result was 64.8 percent.

The most recent National Survey of CSHCN \), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of

CSHCN in each state.

FVCA Council Agencies continued to work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers (FRC) for community resources, support and information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CRISS Medical Eligibility Work Group meets quarterly with CCS medical consultants, hospital and pediatric representatives, to improve consistency in inter-county interpretation of CCS law, regulation.				X
2. CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.				X
3. LAPSNC focuses on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.				X
4. FVCA Council Agencies work with their local CCS agency to provide trainings to CCS employees, and connect families to FRC for community resources, support and information.				X
5. The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.				X
6. CMS Branch and the Medi-Cal program collaborate on the implementation of a pediatric Palliative Care program.				X
7.				
8.				
9.				
10.				

b. Current Activities

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) meets quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region. Biannually a Southern CA medical consultant comes to the CRISS meeting, and a CRISS consultant attends the Southern California meeting..

2) CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.

3) LAPSNC works on increasing parent involvement by inviting representatives from the FRC to meetings, and joining committees.

4) FVCA collaborates with DHCS on an ongoing basis and its member agencies work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.

5) The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) The CCS Workgroup, supported by LAPSNC, meets bimonthly and seeks active parent engagement and involvement.

7) The CMS Branch and Medi-Cal continue to meet and collaborate on the Pediatric Palliative Care Pilot program.

c. Plan for the Coming Year

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) will continue to meet quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region.

2) CHDP, HCPCFC, and CCS programs will continue to report on a performance measure evaluating effective care coordination.

3) LAPSNC will continue to focus on increasing parent involvement by inviting representatives from FRC to meetings, and joining committees.

4) FVCA will continue to collaborate with DHCS on an ongoing basis and FVCA's member agencies will work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.

5) The FCC Work Group will continue to meet 4 or 5 times per year to review county FCC activities, share resources, and plan conferences, trainings, and activities. The group is planning the 2011 annual FCC conference focusing on best practices.

6) The CCS Workgroup, supported by LAPSNC, will meet bimonthly and seek active parent engagement and involvement.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.8	37.5	37.5	38	39
Annual Indicator	37.1	37.1	37.1	37.1	37.4
Numerator					
Denominator					
Data Source		National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	39	39	39	39	39

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2009
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 06 is a National CSHCN Survey measure and is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. For California in 2005-2006, the result was 37.1 percent.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC NCHS, identified approximately 750 parents of children with special needs in each state.

1) CCS social work consultants met quarterly and discussed transition issues.

2) CMS staff collaborated with KASA via conference calls on issues surrounding transition. One

particular topic was a "Transition Toolkit" designed for youth with disabilities. The toolkit is entitled "Things are About to Change" A Young Person's Guide to Transitioning to Adulthood", and became available at www.tknlyouth.info in the fall 2010.

3) CMS continued to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.

4) CMS staff met quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counties continue to be involved in the implementation and evaluation of transition strategies.				X
2. CMS Branch collaborates with CA Health Incentives Improvement Project to market a “Transition Toolkit” and to train CCS programs on its usage.				X
3. CMS social work consultants continue to meet on transition issues.		X		
4. State CMS staff continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.				X
5. State CMS staff continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) CMS is collaborating with the California Health Incentives Improvement Project (CHIIP) which is funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services.

2) CHIIP participated in a panel presentation at the October 2010 Children's Regional Integrated Service System's Conference in which they presented information on the new "Transition Toolkit". Attendees included CCS staff and CCS families.
3)CMS is collaborating with CHIIP on marketing the "Transition Toolkit".

4) CMS social work consultants continue to meet on transition issues.

5) CMS continues to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.

6) As staffing allows, the CMS staff are meeting with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

c. Plan for the Coming Year
1)CMS will continue to collaborate with CHIIP on the "Transition Toolkit" marketing effort.

2)CMS and CHIIP will explore piloting the Toolkit with one or two local CCS programs.

3)CMS and CHIIP are planning online webinar training on the toolkit for local CCS programs and to have a link on the CMS Branch website to the Transition Toolkit.

4) As staffing allows, CMS social work consultants will continue to meet on transition issues.

5) CMS will continue to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.

6)As staffing allows, the CMS staff will meet with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	78.4	78.9	79.4	79.9	82.1
Annual Indicator	79.4	80.6	75.8	76.5	76.5
Numerator	432828	433234	413608	423707	
Denominator	545123	537511	545657	553866	
Data Source		National Immunization Survey, 2008	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual	82.1	82.1	82.1	82.1	82.1

Performance Objective					

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source of percent immunized: Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity‡ and by State and Local Area -- US, National Immunization Survey, Q1/2010-Q4/2010.
Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

The 4:3:1:3:3 series coverage is based on the original definition for this series. CDC made this series coverage available online in the 2009 web tables but not 2010; it is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. Recognizing that some state grantees use this 4:3:1:3:3 measure, the CDC will be including it in future releases of the NIS data on the CDC website. In the future, coverage estimates will be based on the new definition for Hib that takes into consideration the vaccine brand type (i.e. some children only need 3 doses to be up to date, while others need 4 doses to be up to date), this began with the 2009 data.

Notes - 2009
Source of percent immunized: Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity‡ and by State and Local Area -- US, National Immunization Survey, Q1/2009-Q4/2009. Available at: http://www.cdc.gov/vaccines/stats-surv/nis/tables/09/tab26c_43133_race_iap.xls Last accessed February 4, 2011.

Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

a. Last Year's Accomplishments
In 2010, the immunization rate for children age 19-35 months was 76.5 percent; due to methodological changes in data collection, it cannot be compared to previous years' rates. Statewide, the number of fully vaccinated children has been falling steadily since 2004, when 92.9 % of students entering kindergarten had all required immunizations. Only 90.7% were fully vaccinated in 2010, resulting in more children vulnerable to preventable illnesses. The decline in kindergarten immunization rates has been especially marked in the northeast corner of the state with rates between 73 and 75.3% in Calaveras, Mariposa, Nevada and Tuolumne counties. Likewise, Santa Cruz, Marin, Sacramento, El Dorado, Mendocino, Humboldt, Trinity, Shasta and Siskiyou counties all had kindergarten vaccination rates below 85 percent in 2010. Some private schools in these areas, particularly those that cater to college educated, middle to upper income families, have the lowest immunization rates.

MCAH and CMS advocated for families to enroll in Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations should increase. LHJs, including AFLP and BIH, continued to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and promoted the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

In 2010, California saw a pertussis outbreak kill ten children and affect 8,383 others -- the largest epidemic in 63 years. In the same year, California passed Assembly Bill 354 to make a pertussis booster vaccination mandatory for 7th to 12th graders in the 2011 school year. The legislation had been stalled for several years amid concerns that California would have to pay hundreds of thousands of dollars for vaccinations for children on Medi-Cal. Studies show that undiagnosed family members are most likely to infect infants with whooping cough and teens that have not been immunized have been a factor in the spread of the disease. Those most vulnerable to whooping cough are infants too young to be immunized. In 2011, there were no recorded deaths attributed to
Pertussis.

Many local MCAH programs focused activities on immunizations and participated on Immunization Collaboratives and coalitions to increase access to immunizations through health fairs, seasonal flu clinics and public health immunization clinics.

Alameda County has an extensive immunization assistance program. In FY 2010/11 they provided training which emphasized new Medi-Cal services or changes in services or policy, to about 300 physicians, nurses and medical assistants. In addition, they collaborated with the Immunization Partnership of Alameda County (IPAC) to coordinate services for implementation of AB 354. Alameda County MCAH Program also conducted selective reviews at kindergarten schools and feedback was given to the schools on how to improve compliance with California School Law. The Perinatal Hepatitis B program was able to enhance the capacity of providers to integrate Hepatitis B Vaccine (HBV) testing, counseling and informed consent into their prenatal care services and in labor and delivery.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH and CMS advocate for eligible children to join Medi-Cal or HF, both of which cover immunization.		X		
2. Healthy Start (HS), the Health Insurance Plan of California, and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children.			X	
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and AFLP, BIH, and CPSP.				X
4. Nine regional immunization registries, covering 53 of 58 California counties, provide the foundation for a centralized system of maintaining immunization records.				X
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.				X
6. Efforts are underway to improve the electronic exchange of information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.			X	
7. MCAH staff participates in ongoing activities:: serving on local Immunization Coalitions, participating in health fairs, providing provider trainings, making referrals, evaluating data & establishing immunization clinic sites.			X	
8.				
9.				
10.				

b. Current Activities

MCAH work with the IZB in its roll-out of the new adolescent immunizations .Many MCAH LHJs conduct outreach at health fairs and other venues to provide education and resources for childhood immunizations and health insurance. Orange County's will link to the L.A. County Immunization Registry. Programs such as CHVP, AFLP and BIH discuss and encourage clients to keep immunizations up-to-date. With the late start of the flu season (Winter 2012) and widespread geographic distribution, CDPH is recommending influenza vaccination for everyone except for those with contraindications.

Alameda County continues to screen clients for immunization assistance, increase the number of Medi-Cal provider participation in California Immunization Registry (CAIR), and provide schools with training about immunization laws; it is also coordinating community education and outreach to promote "Flu for Everyone" and "Toddler Immunization Month" campaigns. Shasta County has an education campaign targeted at worried parents by creating shastashots.com, a website that provides facts on vaccines and an "ask the nurse" email link. Ventura County, have started organizing vaccination clinics at area parks and schools, and offering a drive-through flu shot station.

CMS and IZB encouraged all California VFC providers to attend the CDC's 1st Online ('Virtual') National Immunization Conference held last March 2012.

c. Plan for the Coming Year

CMS and IZ Branches, Medi-Cal, and MCMC continue to meet three times per year to discuss results of the ACIP-VFC National Meetings. CMS and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH partners with the IZB to provide immunization updates to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy and the importance of influenza vaccination. MCAH will continue to work closely with IZB to provide information on pertussis to MCAH providers.

MCAH and CMS will continue to advocate for and assist families to enroll in low/no cost public and private health insurance entities. Local MCAH programs, including CHVP, AFLP and BIH, will continue to discuss and encourage clients to keep immunizations up-to-date. .

LHJs will be involved in ongoing efforts to improve immunization rates by participating in local collaboratives. The Perinatal Services Coordinators (PSCs) in many LHJs disseminate information on immunizations to local providers participating in the Comprehensive Perinatal Services Program. Local MCAH programs coordinate with schools to provide outreach and education to parents and children to improve immunization rates among elementary and middle school children. Some local MCAH programs are actively planning to address childhood immunization in their communities. For example, El Dorado County is developing a vaccine safety and local resources campaign to target school districts with high Personal Belief Exemption rates.

Immunization rates have an impact on vaccine-preventable disease rates for the population. In general, in order for unvaccinated people to be protected against communicable diseases, approximately 75 to 95 percent of the population has to be vaccinated against them.

California school immunization laws grant exemptions which allow parents to opt out from providing proof that their children have received mandatory vaccinations for medical and philosophical reasons, such as personal, moral or other beliefs. To obtain a personal belief exemption; parents are only required to sign their name to a brief standard exemption statement on the back of the vaccination requirement form. In evaluating data on the rates of exemptions

from CDPH, CDE and the U.S. Census, researchers found that in 2010, California had about 11,500 kindergartners with personal belief exemptions, representing a 25% increase over the previous 2 years. Assembly Bill 2109 was introduced ,and is intended to strengthen California's "personal belief" law to ensure that parents have accurate information and understand that they place their child and other children at risk by failing to get their children immunized [46] .

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	20	19.7	19.4	19.1	17.4
Annual Indicator	19.9	19.1	17.5	15.2	15.2
Numerator	17582	17008	15418	13308	
Denominator	882026	888169	883101	874581	
Data Source		CA Birth Statistical Master File, 2008	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17.4	17.4	17.4	17.4	17.4

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2010 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

Notes - 2009
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2009 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

a. Last Year's Accomplishments
In 2010, births to teens aged 15-17 years continued to decline. The Hispanic teen birth rate decreased 13.6% to 24.7 (per 1,000 female teens aged 15-17 years) and the African American teen birth rate declined 14.8% to 16.1 (per 1,000 female teens aged 15-17 years). The teen birth rate for Whites decreased 8.7% to 4.2 (per 1,000 female teens aged 15-17 years) and the Asian/Pacific Islander teen birth rates decreased 23.3% to 3.2 (per 1,000 female teens aged 15-17 years). Rates for White and Asian/Pacific Islander teens continue to be lower than rates for Hispanic and African American teens.

OFP, Family Planning, Access Care & Treatment program (Family PACT), and the Information &Education Program (I & E) continued their teen pregnancy prevention efforts. However, budget reductions resulted in less program evaluation, education, and outreach for teen pregnancy prevention programs.

OFP developed Requests for Applications (RFAs) for I & E. I&E program design will integrate outreach strategies previously funded under Teen Smart Outreach. Twenty-four I & E grantees were awarded in 2011. I & E conducts primary pregnancy prevention through educational programs that equip teens at high risk for pregnancy with the knowledge, understanding, and behavioral skills necessary to make responsible decisions regarding risky behaviors.

CDPH/OFP was awarded Personal Responsibility Education Program (PREP) funds from the U.S. Department of Health and Human Services, Administration on Children, Youth and Families, administered by the Family and Youth Services Bureau. This Title V funding made available through the ACA provides approximately $6.5 million annually to California through 2014. PREP funds will be used to replicate effective evidence-based program models that have been proven to change behavior, which means delay in sexual activity, increase in condom or contraceptive use among sexually active youth, and/or reduce pregnancy. CA PREP Eligible entities include 19 California counties with the highest teen birth rates.

MCAH continued to fund and monitor AFLP, the case management program for pregnant and parenting teens in 37 CA communities. . AFLP uses a case management model to enhance, through associations with families and community resources, the health, educational potential, economic opportunity, and self-sufficiency of adolescents during pregnancy and parenthood, and to promote healthy, family relationships.
MCAH began to implement a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services, funded through the ACA Pregnancy Assistance Fund (PAF) and administered by the federal Office of Adolescent Health that provides $2 million annually for federal project periods 2010 -- 2013. MCAH is developing a standardized case management model with integrated life planning for AFLP. MCAH is also exploring Group Level Interventions. This grant is called AFLP PYD (Positive Youth Development), and it is being implemented in 11 AFLP sites. First year activities included capacity building through a series of five trainings: Core Competencies for Providers of Adolescent Sexual and Reproductive Health; Positive Youth Development (PYD); Motivational Interviewing and Case Management; Life Planning; and "Pulling It All Together."

Cal-SAFE continued serving pregnant and parenting students. School districts now have full flexibility in directing Cal-SAFE funds. Some school districts have closed or decreased their Cal-SAFE programs, since flexible spending was implemented.

MCAH worked with the Internet Sexuality Information Services to develop the youth component of the First Time Motherhood grant. The text messaging campaign developed 52 weekly texts to forward to teens on areas related to preconception health. A web site has been developed to provide preconception health information and links to teen pregnancy prevention websites. In addition, an electronic photo contest addressing preconception health issues will be held.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP provides case management services to pregnant and/or parenting teens to improve birth outcomes and prevent additional pregnancies.		X		
2. The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to contraception.	X			
3. The CCG Program funds 116 community agencies.		X		
4. Cal-SAFE, operating in 137 school districts, enables expectant/parenting adolescents to improve academic achievement and parenting skills, and provides quality child care/developmental programs.			X	
5. MCAH, OFP, Office of AIDS, and the Sexually Transmitted Disease Branch collaborate with key stakeholders at the state level, to better coordinate efforts in Human Immunodeficiency Virus (HIV), Sexually Transmitted Disease (STD), and teen pregnancy pr				X
6. MCAH, OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-2004.				X
7. MCAH, OFP and key stakeholders collaborate on Core Competencies, a document intended as an interdisciplinary guide for staff and professionals who work on adolescent sexual health issues.				X
8. The Teen SMART Outreach program funded 21 agencies through September 2008.		X		
9. The Male Involvement Program funded 21 agencies through September 2008.		X		
10. The Information & Education program funded 24 agencies in 2011.		X		

b. Current Activities

OFP's primary teen pregnancy prevention programs, I & E and CA PREP, transitioned to MCAH following the Governor's budget decision to move OFP clinical services, specifically Family PACT, from CDPH to DHCS.

MCAH developed and released an RFA for CA PREP funding. Eligible entities in 19 California counties with the highest teen birth rates were awarded CA PREP funds and will begin start-up activities in July, 2012. MCAH is establishing the necessary infrastructure to support effective program implementation including training, technical assistance, and systems for data collection, monitoring and evaluation.
I&E continues its teen pregnancy prevention efforts.

In November 2011, MCAH conducted a competitive RFA process for AFLP with 35 existing contractors applying and successfully awarded. Two current contractors did not apply due to limited funding availability and lack of capacity to respond to the RFA. Following award announcements and subsequent Title V funding reductions, one additional contractor declined to continue the program due to insufficient resources. The number of AFLP sites has declined from 41 in 2009 to 34 in 2012.

The 11 PAF funded AFLP PYD sites conducted capacity building activities. The "Pulling It All

Together" training provided skill building for local partners to practice using the newly developed, PYD-informed My Life Plan modules and corresponding Goal Setting tools in preparation for pilot implementation.

c. Plan for the Coming Year
Seventeen MCAH Local Health Jurisdictions (LHJs) will implement specific teen pregnancy prevention effort that they have planned.

With newly integrated primary teen pregnancy prevention programs, MCAH looks forward to developing an enhanced focus on primary and secondary teen pregnancy prevention and adolescent health promotion. These efforts will include an emphasis on positive youth development and healthy relationships with the goal of promoting adolescent sexual health as well as overall health and well-being. In addition, opportunities to leverage coordination of primary and secondary teen pregnancy prevention efforts will be identified in terms of local and expert input; professional development and training; replication and effective adaptation of evidence-based practice; process and program evaluation; and continuous quality improvement. This youth focus is supported by the local MCAH needs assessments which have identified adolescent health and adolescent reproductive health as local priorities.

MCAH will continue primary teen pregnancy prevention efforts through I & E and CA PREP. The recent transition provides an opportunity to work collaboratively with local partners to support their efforts to maintain optimal teen pregnancy prevention programs within existing resources. CA PREP will continue program implementation and MCAH will work with UCSF, Bixby Center for Global Reproductive Health, and the CA Prevention Training Center to support and monitor local implementation and program quality in an effort to meet or exceed federal performance measures.

MCAH will continue to support LHJs and CBOs that implement the AFLP program, particularly as they address the challenges of ongoing funding reductions. As lessons are learned through AFLP PYD efforts, best practices will be incorporated into AFLP statewide.

MCAH will pilot the AFLP PYD intervention in its 11 funded sites. A formative evaluation will be used to inform modifications to the My Life Plan and Goal Setting tools and processes in preparation for a full pilot and outcome evaluation in subsequent years as resources allow. This formative process will include extensive and iterative local involvement and feedback. To implement the AFLP PYD pilot, , MCAH will continue its work with the University of California, San Francisco, Department of Pediatrics, Division of Adolescent Medicine.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	27.6	28.1	28.6	29.1	29
Annual Indicator	27.6	27.6	27.6	27.6	27.6
Numerator	128373	129671	126908	127505	
Denominator	465121	469824	459813	461974	
Data Source		Dental Health Foundation,	Dental Health	Dental Health	Dental Health

		2006	Foundation	Foundation	Foundation
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	29	29	29	29	29

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 02/21/12 at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf.

*Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 02/21/12.
Denominator source: California Department of Education. Accessed 02/21/12 at http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cChoice=StEnrGrd&cYear=2010-11&cLevel=State&cTopic=Enrollment&myTimeFrame=S&cType=ALL&cGender=B

Notes - 2009
Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 03/09/11 at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf.

*Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 03/09/11.

Denominator source: California Department of Education. Accessed 03/09/11 at http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cChoice=StEnrGrd&cYear=2009-10&cLevel=State&cTopic=Enrollment&myTimeFrame=S&cType=ALL&cGender=B

a. Last Year's Accomplishments
Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The

percent with sealant in California is estimated to be 27.6 percent since 2005 since no new survey has been implemented to update this rate.

The numerator for this performance measure is from the Oral Health Needs Assessment a survey of a representative sample of elementary schools in California in 2004-2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools. The California Office of Oral Health (OOH) partnered with MCAH and the Dental Health Foundation (DHF) to conduct the Oral Health Needs Assessment. In 2010, DHF changed its name to Center for Oral Health (COH) and OOH is now known as the Oral Health Unit (OHU).

To meet the demand for TA at both the state and local levels, MCAH contracts with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. MCAH, CMS, Medi-Cal and OHU are members of the California Oral Health Access Council (OHAC) and the Oral Health Work Group (OHW). OHAC is a diverse panel of stakeholders that are working to improve the oral health status of the state's traditionally underserved populations. OHW assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH, OHU and Medi-Cal are liaisons to the CHDP State Dental Subcommittee whose goal is to increase access to dental care for the CHDP eligible population.

Forty LHJs report oral health activities for children; 23 LHJs report activities focused on pregnant women. Eleven LHJs have a dental coordinator on staff. Other LHJs rely on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations. Many LHJs select WIC sites, pre-schools, and public school locations to deliver these services. MCAH case management programs, such as CPSP, BIH and AFLP, enroll women and their families into Medi-Cal and HF, and provide them with necessary dental referrals. However, dental providers are difficult to find in many locations because few will accept public insurance or agree to treat low-income pregnant women or children under the age of 3.

California law requires that children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). Schools are encouraged to collect and submit data but are not mandated to do so because of state budget cuts. California Dental Association (CDA) collects assessment data from a majority of counties. As of May 2011, 126,409 out of 462,131 eligible children submitted an assessment during the school year. Approximately 22% were found to have untreated decay, consistent with last year's results.

The Children's Dental Workforce Campaign, led by Children's Partnership, is a statewide coalition-based effort aimed at increasing access to dental care for underserved children by expanding the capacity of the dental workforce to deliver preventive and routine restorative services. This group is examining current workforce models, training programs and funding sources.

A HRSA MCHB Targeted Oral Health Services Systems grant allowed COH to develop an innovative program that provides screening, health education, fluoride varnish and dental referral resources to families in 13 WIC sites. Since the end of the grant in 2011, several thousand children have received services. COH created a guidebook to assist dental providers, WIC personnel, and public health advocates in developing additional Early Entry into Dental Care programs in their own communities.

In 2010, a partnership between OHU, COH, California Primary Care Association, and the University of the Pacific was awarded a 3-year HRSA Oral Health Workforce grant. Activities include: developing a dental prevention and treatment pilot project in schools and FQHCs using Virtual Dental Home and direct service models; conducting an assessment of the impact of the elimination of the adult Denti-Cal optional benefit on the current safety net workforce loss; identifying strategies to increase the current dental health workforce; and creating a low-cost culturally competent curriculum and training program for midlevel allied dental personnel.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children.		X		
2. CHDP provides dental screenings for over 1.8 million children a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs.		X		
3. CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement.		X		
4. MCAH Program, with key State stakeholders (e.g. Medi-Cal, State First 5 Commission, CMS and APP), develops and promotes policy strategies that will improve the oral health of its targeted population.				X
5. MCAH Program has contracted with UCSF School of Dentistry for a dental hygienist to serve as the Branch's oral health policy consultant to provide TA at the state and local levels.				X
6. Children are required to receive a dental check-up within 12 months of their enrollment into kindergarten or first grade, whichever is their first year of public school.				X
7. LHJs are working with medical, dental and education providers in community dental health advisory boards to promote preventive oral health practices and provide fluoride varnish applications.				X
8. OHU, COH and partners were awarded a three year HRSA Oral Health Workforce grant to develop dental prevention and treatment models for underserved populations.				X
9. MCAH is disseminating State perinatal clinical oral health guidelines created for providers engaged in the care of pregnant women and their children.				X
10.				

b. Current Activities

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH also dispatches updated information, web links, grant resources and educational materials to local oral health advocates and coordinators. MCAH assists LHJs to develop oral health activities to increase community access and outreach.

The Managed Risk Medical Insurance Board received a grant to help promote dental exams within their Healthy Family Program in 8 counties. This effort is part of the national Oral Health 2014 Initiative.

CDA commissioned a comprehensive report aimed at improving access to dental care for underserved populations. Titled Phased Strategies for Reducing the Barriers to Dental Care in California, it identifies ways to improve access to dental care for the nearly 30 percent of the population that experiences barriers to care. A 3-phased proposal recommends: establish state oral health director under CDPH and optimizing existing resources; focus on prevention and early intervention for children; and innovate the dental delivery system to expand capacity. To begin implementation, CDA and Children's Partnership are sponsoring a legislative bill that will enhance the state OOH with a licensed dentist to serve as dental director. The bill will also authorize a

study to assess the feasibility of additional dental workforce models to provide care for the underserved populations.

c. Plan for the Coming Year

State and local programs will continue to promote oral health. MCAH will encourage LHJs to strengthen strategies to increase the number of children and pregnant women receiving preventive dental services. MCAH will update and integrate oral health educational components into MCAH program guidelines and curricula.

MCAH will provide TA to LHJs, including presentations, resources, and links to grant funding. Educational materials that address early childhood dental decay prevention for mothers and young children will be distributed through MCAH programs. For example, CHDP Dental subcommittee and MCAH have collaborated on developing brochures regarding oral health care and resources for establishing a dental home by age 1 and made available through the MCAH website. CDE has chosen one of these brochures to print in English and Spanish to be offered to Early Head Start and Head Start families this year.

MCAH will continue to promote and disseminate the California perinatal clinical oral health guidelines to health care providers. Since the guidelines were released in 2010, MCAH hopes to detect an increase in the number of pregnant women receiving prenatal oral health counseling. Two multi-part questions from the 2009 MIHA survey will be added back into the 2012 MIHA survey to discern any change among respondents.

DHCS will finalize a ruling that may allow safety-net clinics, like FQHCs, to contract with private dentists within their service area to provide dental care to their patients. This can greatly expand access to dental care for their patients, usually allowing patients to secure appointments with much shorter wait times, without making a significant capital investment in facilities and equipment.

The governor has proposed to merge HF (which provides subsidized health, dental, and vision coverage to eligible children whose family incomes are below 250 percent FPL) into the current Medi-Cal program. Oral health advocates are expressing concern about the potential impact on beneficiaries and provider networks, particularly if there is a movement toward expansion of dental managed care offerings within Medi-Cal. The mandated dental managed care system in Sacramento County is currently under review by DHCS.

MCAH will monitor efforts, including legislation, to expand the dental workforce by identifying successful and sustainable models which increase access to preventive services and treatment for low-income pregnant women, children, and teens.

In 2007, schools lost nearly $30 million in attendance-based district funding due to oral health-related missed school days and cost hospitals $55 million in emergency room visits for preventable dental problems. SB 694 was introduced to create an office of oral health within CDPH to address the need for a strong oral health infrastructure that will provide a comprehensive, coordinated strategy to address the public dental health needs of the state.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance	3.1	3	2.9	2.9	1.6

Objective					
Annual Indicator	2.3	1.7	1.8	1.0	1
Numerator	191	143	148	84	
Denominator	8200066	8184698	8184071	8199138	
Data Source		CA Death Statistical Master File 2008	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2010 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Notes - 2009
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2009 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007-2009 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents and excludes motor vehicle non-traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

a. Last Year's Accomplishments
CIPPP provided 52 issues of the SafetyLit Bulletin- a weekly update of research literature published in scholarly journals and added items to the searchable SafetyLit literature database. To assist with evidence-based decision-making, SafetyLit provided information about the occurrence of and risk factors for unintentional injuries, interpersonal violence, and self-harm to LHJs and non-governmental agencies. SafetyLit.org received > 60,000 unique visitors each week for an average total of 375,000 visitors. About 3% of these are from California. CIPPP worked closely with the California Coalition on Childhood Safety and Health (a group of insurance company representatives and other stakeholders) to provide guidance for forming policies and justifications for positions on safety regulations and legislation. One example was the information CIPPP provided that resulted in strong support for modifying existing CPS law to require booster seats for children up to age eight. Another example was information CIPPP provided to support zero tolerance for texting while driving under California's graduated driver licensing system. In other legislation enacted in 2011, a child who is six years of age is now allowed to sit in the front seat of a vehicle if all other seats are occupied by children under age eight (Chaptered by Secretary of State, Chapter 474, Statutes of 2011). In consideration of the declining funds available to support LHJ's independent injury prevention activities, CIPPP began assisting with their collaboration with community groups (Safe Kids chapters, parent-teacher organizations) that could serve needs of LHJ clients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local MCAH funded programs participating in the SAFE KIDS Coalitions to implement traffic safety training, child passenger safety checks and safety seat distribution, and bicycle helmet education programs.		X	X	X
2. AFLP, BIH, and CPSP provide educational materials on use of car seats and child injury prevention.		X		
3. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.				X
4. The SAC Branch maintains an up-to-date list of locally operated CPS seat programs for use by traffic courts, community agencies, hospitals and clinics.		X		
5. CIPPP builds state and local capacity for injury prevention by providing technical assistance to state agencies and LHJs, including regular reviews of the current injury prevention literature.				X
6. Office of Traffic Safety (OTS) funds “click it or ticket” campaigns for seatbelt safety.			X	
7. SAC runs Vehicle Occupant Safety Program and the SCOTS program			X	X
8. The OTS maintains a Facebook page to discourage drunk driving and share other information on traffic safety.			X	
9. The OTS measures safety seat usage.			X	X
10.				

b. Current Activities
CIPPP established a calendar of online training opportunities and webinars to partially fill the gap created by declining resources and travel restrictions for in-person training opportunities. CIPPP developed age-appropriate recommendations to parents for keeping their children safe at home,

at play, and when traveling. These "Be Safe, Not Sorry" sheets are available in English, Spanish, and Vietnamese languages.

c. Plan for the Coming Year
The planned activities of MCAH, CIPPP and LHJs include continuation of current activities as resources allow. CIPPP will continue to maintain and update SafetyLit and a calendar of online training opportunities and webinars on injury prevention. CIPPP will continue to provide developmental age-appropriate recommendations to parents for keeping their children safe at home, at play, and when traveling. Future "Be Safe, Not Sorry" information sheet series will be updated when appropriate--such as with the change in the booster seat law and the sheets will be made available in English, Spanish, and Vietnamese languages.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	71	71.5	72	65	64.2
Annual Indicator	61.6	59.9	62.3	59.5	59.5
Numerator	260565	227520	237585	210982	
Denominator	423075	379768	381282	354888	
Data Source		MIHA, 2008	MIHA	MIHA	MIHA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	64.2	64.2	64.2	64.2	64.2

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: 2010 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health.

Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

Notes - 2009
Source: 2009 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health.

Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

Data for 2007-2009 should not be compared to 2006 due to changes in the MIHA survey. The MIHA breastfeeding question changed in 2007 to breastfeeding at 3 months, compared to breastfeeding at 2 months in 2006 and prior years.

a. Last Year's Accomplishments

In 2010, 59.5 percent of mothers reported breastfeeding their infants at three months post-partum which is slightly lower than previous years. African American (47.4%) and Hispanic (51.2%) mothers were less likely than White (69.9%) and Asian/PI (75.0%) mothers to breastfeed their infants at three months of age.

MCAH programs promoted exclusive breastfeeding. BBC: a hospital breastfeeding quality improvement and training project was presented at the 2010 Academy of Breastfeeding Medicine and 2011 Association of Maternal and Child Health Programs annual meetings. Technical assistance to implement BBC was offered to all RPPC regions by PAC-LAC until June 2011.

MCAH shared information with its programs during World Breastfeeding Week and encouraged county and community-based organizations to participate.

MCAH coordinated with the California Obesity Grant, WIC, WIC Association, and Breastfeeding Coalition to celebrate World Breastfeeding Week with a breastfeeding walk, write testimony to IOM on preventive services and durable medical goods that promote and support breastfeeding and host the first State Hospital Breastfeeding Summit in 2011.

MCAH has representation on the U.S. Breastfeeding Committee and ASTPHND MCH Nutrition Council which address policy, programs and breastfeeding services. MCAH was on the planning committee for a joint USBC-ASTPHND symposium on breastfeeding; it was offered at the 2011 ASTPHND meeting.

MCAH was involved in the nutrition revisions of Caring for Our Children: National Health and Safety Standards: Guidelines for Out-of-Home Child Care Programs, with emphasis on breastfeeding.

MCAH led the development of a CDPH lactation accommodation policy, researched a "bring-your-baby to work policy" for the CDPH obesity program. MCAH added a webpage for CDPH employees on lactation accommodation and updated the CDPH and MCAH breastfeeding webpages.

There are several local activities that promote breastfeeding. Humboldt's Breastfeeding Task Force authored breastfeeding in the workplace and safe infant sleeping articles for the Department of Health and Human Services newsletter. A breastfeeding resource brochure was sent to obstetric and pediatric providers, community partners such as play groups and FRCs.

The Imperial County Breastfeeding Coalition hosted the World's Largest Baby Shower and shared nutrition tips for breastfeeding moms.

The Kings County Breastfeeding Coalition (KCBC) distributed a breastfeeding resource and obtained a Board of Supervisors resolution to declare August 2010 as Breastfeeding Awareness Month. Coalition members participated in the Central Valley Grow Our Own Lactation Consultant Training Program. An advocate reported about the 2011 Breastfeeding Summit at a Lunch &

Learn Breastfeeding Session and spoke at the 2011 KCBC breastfeeding conference.

The Breastfeeding Task Force of Greater Los Angeles held three-hour trainings for human resources professionals on the business case for breastfeeding. The MCAH Director is advocating for a workplace breastfeeding policy at the city level.

Mono County Breastfeeding Task Force stopped the distribution of infant formula marketing bags to new mothers at a local hospitals. Breastfeeding-friendly bags were created and distributed to all new mothers.

The Breastfeeding Coalition of Nevada County provided and staffed a comfortable place for women to feed and change their babies at various venues. They provided crib cards for mothers to use to ask hospital staff to not give formula or pacifiers to their infants. The Coalition staffed a 24/7 breastfeeding warm line and educated members about safe infant sleeping. They collaborated on a Breastfeeding Peer Counseling program through WIC.

San Diego MCAH staff met with American Red Cross, WIC, Epidemiology, Bioterrorism and Emergency Medical Services staff to recommend emergency shelters that consider the needs of lactating and pregnant women in an emergency.

The Sonoma County Breastfeeding Coalition promoted workplace lactation accommodation through awards and recognition, used public libraries to raise awareness of breastfeeding benefits, developed "Lactivists" with a Facebook page linked to public health and supported a "Positive Images of Breastfeeding" photo contest. The Sonoma Native Breastfeeding Council designed diaper bags for patients who exclusively breastfed for at least 30 days. They facilitated having a breastfeeding tent available at Gathering of Nations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed.		X		
2. CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes.		X		
3. BIH collaborates with local breastfeeding coalitions to promote breastfeeding in several counties.		X		
4. CPSP promotes breastfeeding through nutrition assessment and counseling.	X			
5. MCAH is participating on the CDPH Obesity Prevention Group as breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
6. MCAH staff help promote local breastfeeding coalitions, including participating at the California Breastfeeding Coalition meetings.				X
7. MCAH is providing toolkits, training and TA (via RPPC) to staff at labor and delivery hospitals to improve hospital lactation policies.		X		
8. MCAH maintains the CDPH and MCAH website's breastfeeding pages which includes breastfeeding information and answers many questions that local programs and the public may have.				X
9.				
10.				

b. Current Activities
MCAH hospital initiation breastfeeding data is posted online and was used by the California WIC Association and UCD to produce a 2012 Hospital Breastfeeding Rates Report & County Fact Sheets. MCAH collaborated with CDC to show that evidence-based policies and practices measured by mPINC are associated with increased exclusive breastfeeding rates in California hospitals; results were shared at the 2012 Hospital Breastfeeding Summit.

PAC-LAC, a RPPC region and MCAH published a report outlining elements and lessons learned from BBC. MCAH offers technical assistance to implement BBC and worked with FHOP to develop a BBC/breastfeeding webinar and breastfeeding fact sheet.

Per California Health & Safety Code SS123365, WIC and MCAH finalized a hospital administrators web-based breastfeeding policy curriculum. MCAH is working with Licensing and Certification on a webinar to prepare hospital evaluators for Health & Safety Code SS123366: Hospital Infant Feeding Act, requiring hospitals to have a breastfeeding promotion policy by 2014 using guidance from the Baby-Friendly Hospital Initiative or CDPH Model Hospital Policy Recommendations.

MCAH is represented on the Emergency Preparedness and Marketing workgroups., MCAH participates in RPPC's emergency preparedness efforts for birthing hospitals and posted related resources on the web.

For home visiting efforts, MCAH developed breastfeeding benchmark indicators and is researching WIC's Peer Counselor Curriculum.

c. Plan for the Coming Year
Of the 134 birth facilities in the U.S. certified as baby-friendly as of May 2012, 54 are in California and MCAH aims to increase this number in the coming FY through breastfeeding promotion activities.

MCAH will support CDPH and DHCS in adhering to California Health & Safety Codes SS 123360 and SS 123365 and SS123366 in creating a public health campaign to provide breastfeeding information and referrals, making available an 8-hour training course that promotes exclusive breastfeeding, and assisting hospitals in developing policies to support breastfeeding by keeping the Model Hospital Policy Recommendations Toolkit and hospital quality improvement resources updated. By 2013, Kaiser plans to have all 29 of its birthing sites either as being designated Baby-Friendly or join a program of the Joint Commission, the national nonprofit that accredits hospitals, which aims to have as many new moms as possible feeding their babies only breast milk, no formula, when they leave the hospital.

MCAH promulgates breastfeeding information and referrals. MCAH will investigate using mother-to mother support, fathers and grandmothers to support breastfeeding. MCAH will advocate for 1) breastfeeding support in childcare and emergency preparedness efforts and 2) marketing of infant formula is conducted in a way that minimizes its negative impacts on breastfeeding.

MCAH will host and support conferences and meetings such as the 2013 Hospital Breastfeeding Summit, California Breastfeeding Coalition, and Childhood Obesity Conference. MCAH will continue to meet bimonthly with state WIC breastfeeding staff to coordinate efforts.

MCAH will continue to monitor California infant feeding patterns, including breastfeeding initiation, duration and exclusivity, and maternity care policies and practices that support breastfeeding through the NBS Program-to monitor in-hospital infant feeding practices; California MIHA Survey to monitor breastfeeding initiation, duration and exclusivity, as well as hospital experiences and worksite accommodations that affect breastfeeding; and CDC mPINC Survey to monitor maternity

care policies and practices that affect breastfeeding.

LHJs will promote breastfeeding. For example, Kings County will collaborate with the local breastfeeding coalition to develop a "breastfeeding friendly sites" directory. Marin Breastfeeding Coalition will create a Facebook page. Marin will assist the county to adopt a workplace breastfeeding policy and provide training for department heads on their roles and responsibilities around supporting a breastfeeding-friendly workplace. Mendocino will develop at least one protocol incorporating breastfeeding support in the MCAH Field Nursing home visiting program.Solano County is in its 7th year of implementing the "More Excellent Way," an African American, peer counseling, church-placed infant feeding and parenting training and intervention program.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75	85	95	95	98
Annual Indicator	73.3	93.2	98.0	99.0	99
Numerator	415867	515062	517247	505847	
Denominator	567527	552618	527897	510981	
Data Source		Office of Vital Records birth certificate data	Office of Vital Records	Office of Vital Records	Office of Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99	99	99	99	99

Notes - 2011
Manual indicator is reported for 2011 based on 2010 results.

Notes - 2010
Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge for FY 2010.
Denominator: Number of live births by occurrence in California in FY 2010.

Notes - 2009
Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge for FY 2009.
Denominator: Number of live births by occurrence in California in FY 2009.

a. Last Year's Accomplishments
1) The CMS Branch provided TA and consultation support to HCCs to ensure that all general acute care hospitals with licensed perinatal services provide hearing screening tests to all newborns in a manner consistent with NHSP standards and requirements.

2) The CMS Branch continued to facilitate the NHSP Quality Improvement learning collaborative.

3) The CMS Branch worked with the Speech Language Pathology and Audiology licensing board regarding quality of care issues and standards of audiologic practice.

4) The CMS Branch worked with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing, screening and audiology services.

5) The CMS Branch executed amendments to the interagency agreements with the CDE and the University of California Davis (UCD) Medical Center to implement the MCHB Teleaudiology Grant to improve the quality of and access to audiology services and minimize the shortage of pediatric audiology providers in Northern California.

6) The CMS Branch collaborated in the implementation of the parent support grant from MCHB.

7) The CMS Branch worked with the NHSP DMS vendor, Neometrics, to prepare the DMS for implementation in hospitals. The DMS was used by one HCC and three pilot hospitals.

8) The CMS Branch was awarded a 5-year Centers for Disease Control and Prevention Cooperative Agreement to continue support activities in the implementation of the DMS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CMS Branch will work with the CDE to support the implementation of the parent support activities in the grant from MCHB.		X		
2. The statewide data management service for the NHSP will be rolled out to the remaining HCCs and additional hospitals.				X
3. TA and consultation support will continue for all HCCs.		X		
4. CMS Branch will ensure that all general acute hospitals with licensed perinatal services will participate in the NHSP expansion.			X	
5. CMS Branch continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities
1) The remaining and all new general acute care hospitals with licensed perinatal services are being certified for participation in the NHSP.

2) CMS continues collaboration in the implementation of the parent support grant from MCHB.

3) The NHSP DMS vendor, is implementing the DMS in additional hospitals and all three HCCs.

4) CMS is an active participant in the NHSP QI learning collaborative.

5) CMS provides technical support to the HCCs.

6) CMS to collaborate with UC Davis Hospital to execute the activities in the teleaudiology grant. Six patients have received complete diagnostic audiological evaluations via telehealth between December 2011 and March 2012.

7) CMS is applying for continued funding from MCHB for the parent support and teleaudiology projects.

c. Plan for the Coming Year
1) CMS will finalize the certification of any remaining or new hospitals.

2) CMS will continue to collaborate in the implementation of the parent support grant from MCHB, assuming new grant is awarded.

3) The DMS for NHSP will be rolled out in a phased implementation process to 1/3 of the certified hospitals throughout the state.

4) CMS will continue participation and facilitation of the NHSP QI learning collaborative.

5) TA and consultation support will continue for all HCCs to ensure compliance with NHSP standards and requirements.

6) The Audiology Telehealth pilot project in the rural northern region of California will allow rural families to receive local services without any lengthy travel, assuming new grant is awarded.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	13.5	13.3	13.1	12.9	10
Annual Indicator	11.2	11.0	11.2	11.2	11.2
Numerator	1185414	1167278	1190554	1185414	
Denominator	10584055	10611615	10616624	10613742	
Data Source		Current Population	Current Population	Current Population	Current Population

		Survey, 2008	Survey	Survey	Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	10	10	10	10	10

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
The estimated percent of uninsured children age 0-18 years was computed by the Kaiser Family Foundation using the 2010 Current Population Survey March 2011 release.

The denominator of children age 0-18 years was from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050, Sacramento, CA July 2007.

The numerator wass calculated by MCAHf by multiplying the percent uninsured by the denominator (11.16867 * 10,613,742 = 1,185,414).

Notes - 2009
Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2010 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail,2000-2050. Sacramento, California, July 2007.

The numerator was calculated by multiplying the percent uninsured by the denominator. To be more precise in calculating the numerator, for 2009, the unrounded value of the percent uninsured was used; in previous years, the value of the percent uninsured was rounded off to the first decimal place.

a. Last Year's Accomplishments
The percent of uninsured children in California has decreased since 2000 when the percent of children without health insurance was 15.7 percent. After slight increases in 2005-06, the percent without insurance is at 11.2 percent in 2010. Despite this success, over a million children still lack coverage. Data for NPM 13 are based on the U.S. Current Population Survey.

In an effort to decrease the number of uninsured children, a comprehensive outreach and education campaign continued to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers include a shortened joint application for both Medi-Cal and HF, elimination of quarterly status reports under Medi-Cal, and on-line enrollment. Health-e-APP, a web-based HF application, became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process.

Through the CHDP Gateway, any child under 19 years with family income at or below 200 percent FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal or HF and given a temporary Medi-Cal Benefits Identification Card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through December 2009, 4.4 million children were pre-enrolled in the Gateway, and 79 percent requested a joint application for Medi-Cal and HF. From June 2004 through December 2009, 358,193 infants were automatically enrolled in Medi-Cal, with 73,166 infants automatically enrolled as the result of a Gateway transaction in 2009. Significant shares of the uninsured but eligible children are served by the Special Supplemental Nutrition Program for WIC. Senate Bill (SB) 437, enacted in October 2006, created the WIC Gateway. This allows parents and caretakers of infant and child WIC applicants to submit a simple electronic application to simultaneously obtain presumptive eligibility for Medi-Cal or HF and apply for enrollment to either as well.

MCAH programs, including AFLP, BIH, and CPSP, encouraged and facilitated enrollment in Medi-Cal, HF and CHI. Efforts included public awareness media campaigns and other community education and outreach efforts. For example, Humboldt County implemented local systems changes to assure that infants born to mothers on Medi-Cal are immediately enrolled in Medi-Cal and to better track children accessing health care through the CHDP Gateway.

CDPH, DHCS and MRMIB, in collaboration with stakeholders, continued to promote the WIC Gateway to streamline and expedite health insurance enrollment for children served at local WIC agencies.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources. The CMS Branch analyzed CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

State funding for Certified Application Assistants (CAA) was terminated as of July 2003 due to the state budget crisis. Some CAAs continued working on a county-funded or volunteer basis, and the State continues to provide CAA trainings. CAAs work with families in clinics, community centers, schools, and homes, helping them navigate the complex eligibility structures of Medi-Cal and HF.

Children received coverage from four main sources of coverage: job-based insurance, privately purchased insurance, Medi-Cal and HF. According to the 2009 CHIS public coverage insured 31.8% of all children in the state, compared to 24.7% in 2007, prior to the Great Recession. The percent of children covered by job based insurance decreased from 52.2% to 49.4 percent.

Many counties have created Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal or HF coverage. CHI is a collaboration of 29 local CHI's dedicated to ensuring that all California children have access to quality health coverage. Together, the CHI's emphasize streamlined enrollment into HF, Medi-Cal and Healthy Kids insurance programs, and share a goal of creating and maintaining a sustainable health care program for all children in California.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH programs and LHJs encourage and facilitate enrollment in Medi-Cal, HF, CHI and other low cost insurance programs via community outreach and education activities and local Toll-Free Telephone referral lines.			X	

2. CMS Branch works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF.				X
3. CHDP provides information and materials in multiple languages for the Gateway				X
4. CDPH and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MCAH programs, including AFLP, BIH, and CPSP, encourage and facilitate enrollment in Medi-Cal, HF and CHI through outreach, education and referral programs.

DHCS and MRMIB implement and support improvements in the process of determining eligibility and enrollment in Medi-Cal and HF.

Local MCAH programs provide outreach and referrals to health insurance plans for pregnant women, infants and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, provision of case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

Local CHDP programs inform new providers about the Gateway and direct them to CHDP Gateway resources. CMS will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

c. Plan for the Coming Year
MCAH programs, including AFLP, BIH, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal, HF and CHI through outreach, education and referral programs.

DHCS and MRMIB will continue to implement and support improvements in the process of determining eligibility and enrollment in Medi-Cal and HF. The Governor's Budget has proposed moving HF enrolled children into the Medi-Cal program. The Legislature will be evaluating this proposal. The Department of Health Services will be implementing this change if the proposal passes the Legislature and is signed by the Governor.

Local MCAH programs will continue to provide outreach and referrals to health insurance plans for pregnant women, infants and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, provision of case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

Local CHDP programs will continue to inform new providers about the Gateway and direct them

to CHDP Gateway resources. CMS will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	33.6	33.6	33.5	33.5	31.4
Annual Indicator	33.6	33.3	32.9	33.4	33.4
Numerator	104896	100447	109446	95025	
Denominator	312190	301643	332663	284506	
Data Source		PedNSS, 2008	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	31.4	31.4	31.4	31.4	31.4

Notes - 2011
A manual indicator is reported for 2011 based on 2010 results.

Notes - 2010
Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for CY 2010. Table 12C, 2010 Pediatric Nutrition Surveillance, Summary of Trends in Growth and Anemia Indicators, Children Aged < 5 years.

Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the>=95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at:
http://www.dhcs.ca.gov/services/chdp/Pages/PedNSS2010data.aspx. Last accessed on April 25, 2012.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source.

Notes - 2009
Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2009. Table 12C, 2009 Pediatric Nutrition Surveillance, Summary of Trends in Growth and Anemia Indicators, Children Aged < 5 years.

Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the >=95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at: http://www.dhcs.ca.gov/services/chdp/Documents/PedNSS/2009/12C.pdf. Last accessed on February 24, 2011.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

a. Last Year's Accomplishments

In 2010, California identified 33.4% had a BMI at or above the 85th percentile for children ages 2 to 5 years. To prevent this high rate, MCAH focused on modifying risk factors before pregnancy, in utero and in infancy by promoting optimal preconception weight, euglycemia and breastfeeding,

In 2010, the MCAH Nutrition and Physical Activity Coordinator was a Board member of the Association of State & Territorial Public Health Nutrition Directors (ASTPHND), which works to strengthen nutrition policies, programs and environments at state and national levels. MCAH and CMS participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs. MCAH and CMS provided expert input for planning the 2011 Childhood Obesity Conference.

MCAH helped author national guidelines released in 2011 promoting optimum nutrition, breastfeeding and physical activity in childcare centers. State and local CHDP nutritionists developed and implemented nutrition education, provided consultation/training and monitored childhood obesity. On-line train-the-trainer modules for assessing and managing overweight children were used by MCMC Health Plans and CHDP providers. CHDP trained medical staff on the use of the World Health Organization growth charts.

MCAH addressed childhood obesity locally. Alameda County hosted workshops about adolescent overweight/obesity interventions, developed childhood obesity peer education trainings for churches and a street-level nutrition and exercise project for day laborers. Berkeley had a Walk & Roll to School Day to encourage walking/biking/rolling to school. Imperial's Childhood Overweight/Obesity Prevention Alliance developed provider standards-of-care and best practices on childhood overweight/obesity. They established gardens in local preschools and promoted healthy eating and exercise through health fairs; provided support to schools, cafeterias, and local grocery stores; collaborated on a Mall Walk; and provided food demonstrations in libraries, preschools and grocery stores. Long Beach implemented a wellness forum for churches to promote healthy eating to African-American families; their Best Babies Collaborative provided education to women/teens on nutrition. Mono County held a Screen Turnoff Week campaign and focused on avoiding sugar-sweetened beverages, eating a healthy breakfast, fruits and vegetables, and being active for at least an hour every day; they implemented a 10-week program with cooking demonstrations and nutrition/physical activity for obese school children and their families. Plumas Home Visiting Coalition advocated for obesity prevention and nutrition in all home visits. San Francisco developed halthy recipes including in Chinese and Spanish. They implemented a "Re-Think Your Drink" Campaign; their Headstart Services Advisory Committee provided education on reducing "junk food" in children's diets and improving access to fresh produce. In Santa Cruz, nutrition classes were given at the kindergarten level with quality physical education, including rhythms and dance.

Efforts were undertaken to help community environments support optimal nutrition and physical activity. Contra Costa held Healthy and Active Before 5: A Community Summit to promote organizational policy changes around breastfeeding, healthy food/beverages and highlight local success stories. L.A. assessed nutrition and physical activity practices in licensed child care centers. Merced established a community garden with classes and evaluated a walkable and safe community. Mono County worked with a school district to reinstate the salad bar and remove unhealthy foods from school menus; sport organizations to foster sport participation and facilities; and Sierra Bounty to unite farmers with their local market and increase accessibility to fresh, organic produce. To create a plan for increasing access to healthy food, Sonoma evaluated communities' access to healthy/unhealthy food, farmers markets, emergency food providers and local transit; walkability of neighborhoods and advertising of unhealthy food . Stanislaus County collaborated with Modesto City to fund safer streets/sidewalks using Safe Routes to School grants. Ventura County worked with school districts to improve the quality of food served.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Data collection from CHDP nutrition assessments for the Pediatric Nutrition Surveillance System (PedNSS) continues.		X		
2. CHDP program benefits include cholesterol and fasting blood glucose screening tests for children at risk for obesity, the complications of obesity and at risk for cardiovascular disease.	X		X	
3. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training modules for CHDP providers and office staff, and coordinate follow-up and referrals to related programs.		X		X
4. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				X
5. BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity.		X		
6. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among infants and pre-school aged children.				X
7. BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
8. MCAH Offers MCAH LHJs a “Here is Where Healthy Starts” award for policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X
9. MCAH and CMS collaborate with the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X
10.				

b. Current Activities

Two new laws support CDPH efforts to reduce obesity: one makes obtaining federal funds easier for CDPH and one establishes a "Safe Routes to School Program."

As part of a lifecourse approach to prevent obesity, a new MCAH webpage shares policy and community-based interventions that support healthy weight for reproductive-aged women. MCAH assisted in developing interconception guidelines/handouts for women with risks, e.g., gestational

diabetes, in a prior pregnancy. MCAH is evaluating the Perinatal Food Group Recall for accuracy and ease of implementing by CPSP Community Health Workers; it sets a goal and identifies food group and calorie deficiencies/excesses. MyPlate for Moms was finalized and encourages pregnant/breastfeeding women to eat healthy meals, with limited sugar, solid fats and salt. It is a primary message for CPSP/ AFLP and is tailored for CDAPP Sweet Success.

MCAH finalized English and Spanish healthy cookbooks for AFLP to encourage healthy eating and physical activity. MCAH collaborated with FHOP to create a healthy weight webinar and fact sheet. MCAH is updating nutrition and physical activity guidelines for AFLP, BIH, CDAPP Sweet Success and CPSP. MCAH researched nutrition, physical activity and breastfeeding benchmarks for home visiting and disseminated WIC child nutrition and baby behavior educational materials to local MCAH.

c. Plan for the Coming Year

MCAH will continue to collaborate with state programs, advocates, experts and local MCAH Directors to prevent overweight and obesity in children. Messages and products will be shared with MCAH partners via the MCAH website, email and other mechanisms.

MCAH and CMS will work with OPG to integrate obesity prevention into CDPH programs and develop an action plan and funding proposals. MCAH and CMS are on the Planning Committee for the 2013 Childhood Obesity Conference. MCAH will continue to work on nutrition policy development with ASTPHND and serve on the MCH Nutrition Council Steering Committee.

MCAH will collaborate with experts and LHJ MCAH Directors to address MCAH's role in utilizing strategies and tools to advocate for environmental changes to support optimum nutrition, physical activity and breastfeeding. Materials will be found on the MCAH webpage and shared by webinar.

MCAH will explore ways to promote optimal nutrition, physical activity and breastfeeding in home visiting.

In collaboration with the University of California Los Angeles (LA), a CPSP Food Group Recall will be evaluated by comparing it with the 24-hour Recall and Food Frequency questionnaires in collecting diet intake of perinatal women; community health workers focus group results about usability will also be reported.

Train the trainer modules for assessing and managing overweight children located on the CHDP website will be utilized by MCMC Health Plans and CHDP providers. CHDP will be offering provider office staff training on the use of the WHO growth charts (based on CDC PedNSS WHO growth chart training curriculum).

PedNSS has been discontinued by CDC. CMS is working with UC Berkeley Center for Weight and Health to transfer to them the California data collection and analysis, dependent on funding which is currently being pursued.

Examples of local MCAH plans include Alameda's nurses' training on how to promote healthy eating habits and increased physical activity in their female clients of childbearing age. Alpine will determine the BMI of 7- 8th grade students and provide type 2 diabetes information. LA will recruit child care centers to participate in a study to improve the nutrition and physical activity practices in licensed child care centers. Modoc will present on Harvest of the Month to preschools and kindergartens. Monterey will partner with the Nutrition Network and local schools to increase physical activity and healthy nutrition and provide cooking demonstrations to migrant families. Riverside will update a Child and Adolescent Obesity Provider toolkit. San Benito will provide nutrition and physical activity education to 5th grade students using the Power Play Curriculum. San Francisco will develop guidelines to improve physical activity and nutrition in child care

centers and after school programs. Stanislaus will develop a built environment that is supportive of physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.7	3.6	3.5	3.4	2.6
Annual Indicator	2.6	3.3	2.8	3.0	3
Numerator	14706	18078	14417	14824	
Denominator	556252	542822	519623	498106	
Data Source		MIHA, 2008	MIHA	MIHA	MIHA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: 2010 Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2010.

Description: In 2010, 3.0 percent of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. In 2010, African American and White women had the highest rates of smoking in the last trimester of pregnancy (7.7 and 6. 2 percent, respectively) compared to Latina (1.0 percent) and Asian/Pacific Islander (0.7 percent) women. Reported smoking declined in each of these groups since 2008, with the exception of Latina women, whose rate did not change.

Notes - 2009
Source: 2009 Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2009.

a. Last Year's Accomplishments

In 2010, 3.1 percent of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. Though the prevalence of smoking during the last trimester of pregnancy increased slightly between 2009 and 2010, the prevalence has shown substantial decline since 1999, when the prevalence was 5.7 percent among all women in California.

In 2010, African American and White women had the highest rates of smoking in the last trimester of pregnancy (7.7 and 6. 2 percent, respectively) compared to Hispanic (1.0 percent) and Asian/Pacific Islander (0.7 percent) women. Reported smoking declined in each of these groups since 2008, with the exception of Hispanic women, whose rate did not change.
The state's adult smoking rate has hit a record low of 11.9 percent in 2010, making California one of only two states to reach the HP 2020 target of reducing the adult smoking prevalence rate to 12 percent.

One of California's biggest examples of its influence on public health law is tobacco regulation. In 1988, California was the first state to tax cigarettes to fund a tobacco control program. Ten years later, California banned smoking in public places such as trains, planes, buses, workplaces and restaurants. Now, about half of the states have similar policies about smoking in public places. California became a guide for developing anti-smoking policies.

In 2011, two new tobacco-related bills were signed into law. AB 795 provides authority to the governing bodies of the California State University and each community college district to enforce smoking policies by citation and fine. SB 332 was signed into law and would authorize a landlord of a residential dwelling unit to prohibit the smoking of tobacco products on the property premises or in a dwelling unit.

Efforts to reduce and prevent smoking continue to be prominent features of MCAH programs that serve pregnant women and teens. AFLP provided smoking exposure assessment and cessation assistance to pregnant teens. BIH provided health education and health promotion related to smoking cessation in groups and case management for African-American pregnant and parenting women. CPSP included smoking cessation as one goal for improving pregnancy outcomes. CPSP guidelines, "Steps to Take," assisted providers and practitioners with health education, nutrition, and psychosocial interventions. Handouts, in English and Spanish, were available for CPSP to educate women about smoking cessation.

Smoking cessation is a key part of preconception care. The Preconception Health Council of California (PHCC) provided information, tools and resources focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use. Low-literacy fact sheets on the PHCC's website, www.everywomancalifornia.org, encourage women and their partners not to smoke in the event that they may have a baby in the future. In 2010, PHCC consumer handouts, including those on smoking and alcohol, were available in Spanish via the PHCC's website and www.cadamujercadadia.org.
MCAH was awarded a First Time Motherhood grant to develop and test preconception health messages, including smoking prevention and cessation.

CTCP supported statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California. One project, Protecting the Hood Against Tobacco Scum- Los Angeles (PHATS-LA), was a smoking cessation intervention in L.A. in which most participants were low income and African American. LA's MCAH provided data early on and connected CTCP with BIH. Data from follow-up surveys were collected and are being used to assess the impact of the PHATS-LA project. CTCP released "Creating Tobacco Turbulence: A Tobacco Quit Plan for California," to guide tobacco cessation efforts.

The California Smokers' Helpline provided intensive tobacco cessation counseling, which includes tailored counseling services for pregnant women, teens, and adults in multiple languages. California Medi-Cal made changes to its Contract Drugs List and now includes up to 14 weeks of Nicoderm CQ; Zyban patches or behavior modification support and this new policy was communicated to MCAH partners and programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP assess clients for smoking habits and exposure to second hand smoke and discuss the risks of smoking for the mother and baby during pregnancy and after birth.		X		
2. BIH clients receive education about smoking and health; the BIH Scope of Work includes smoking cessation to reduce low birth weight.		X		
3. CPSP guidelines assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines; handouts are also available, in English and Spanish, to educate women about smoking cessation.		X		
4. The California Tobacco Control Program supports statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California.		X		
5. The California Smokers' Helpline provides tailored counseling services for teens, adults, and pregnant women in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese.		X		
6. Diabetes educators throughout California have joined forces with the California Diabetes Program and the California Smokers' Helpline to assist patients with diabetes to quit smoking.				X
7. PHCC has developed a website with information for consumers and providers about health for women of reproductive age. It includes information about smoking during pregnancy and links to resources in English and Spanish.				X
8.				
9.				
10.				

b. Current Activities

AFLP, BIH, and CPSP continue smoking assessment, education, and cessation support activities for pregnant and parenting women. AFLP clients are assessed and counseled at entry and annually for past, current, and second hand smoke exposure. The new PYD intervention will facilitate client-driven life goal development in areas including tobacco use. BIH provides smoking cessation health education and promotion in the new group intervention which was pilot tested this year. Clients who use tobacco products are identified and referred. Biannual trainings for CPSP providers include smoking cessation health education.

The MCAH First Time Motherhood grant campaigns formally ended, but materials continue to be used to address preconception health behaviors in Black, Latina, and young women.

CTCP continues to fund the Smokers' Helpline and projects that facilitate community norm change and support local tobacco control efforts.

To shift toward a more pragmatic harm reduction strategy, the PHCC revised its EVERYDAY

mnemonic recommendation to "Avoid tobacco, alcohol and drugs. Or, use birth control until you can." This message was coupled with cessation resources for smokers and the development of clinical preconception care guidelines.

MCAH monitored Senate Bill 575 which has been held in committee without recommendation since July 6, 2011. This bill would expand the workplace smoking ban to cover employee common spaces, tobacco shops, and private residences used for business.

c. Plan for the Coming Year
LHJs will continue their smoking cessation activities, including outreach, education, referrals, data collection, and data analysis.

AFLP, BIH, and CPSP will continue activities to promote smoking cessation and as necessary, update health education and training materials. With the full implementation of the piloted BIH group intervention, there will be opportunities to educate pregnant and parenting African-American women on the benefits of quitting smoking for mom's health as well as the health of the baby. CPSP updates training materials periodically; this would include updating health education handouts and information about smoking cessation.

As part of Reproductive Life Planning, MCAH programs encourage pregnant and parenting teens to set personal goals that support smoke free lives for them, their children, and unborn babies.

The PHCC will continue to provide information, tools and resources to local communities focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use.

The California Smokers' Helpline will continue to provide intensive tobacco cessation counseling via the telephone and access to materials through its website. CTCP will continue to provide technical assistance, resources, and/or services to the California tobacco control community. The California Diabetes Program, in collaboration with CTCP and diabetes educators, will continue to participate in the "Do You cAARd?" (Ask, Advise, Refer) campaign to help patients reduce their risk of complications and improve their health. The campaign includes a gold "TAKE CHARGE" card to be handed out to encourage use of the California Smokers Helpline.

MCAH will continue efforts to prevent and reduce tobacco use by pregnant women and women of reproductive age. Coordination with existing programs and initiatives, such as those developed statewide and locally via CTCP can be explored. Additionally, the expansion of covered preventive services via provisions of the ACA, including those for smoking cessation by pregnant women, represents an opportunity to reduce tobacco use and the burden of related health outcomes for MCAH population. The PHCC has developed preconception health screening guidelines to help providers take advantage of this clinical opportunity.

At the policy level MCAH will collaborate with CTCP to monitor their new local policy database. MCAH will explore opportunities to examine smoking trends in relationship to local policies and policy changes in multiunit housing prohibition, tobacco retail license fees, sampling ordinances, and second-hand smoke policies. Meanwhile, all University of California campuses are banning cigarettes over the next 2 years, to both protect nonsmokers from secondhand smoke and prevent young people from smoking.. If young people can stop smoking, or never start smoking, before they reach their late 20s, they will be unlikely to ever develop the habit as older adults.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4.7	4.7	4.6	4.6	4.1
Annual Indicator	4.1	4.4	4.7	4.9	4.9
Numerator	122	134	144	150	
Denominator	2955147	3019105	3055826	3054421	
Data Source		CA Death Statistical Master File, 2008	CA Deah Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.1	4.1	4.1	4.1	4.1

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
2010 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337).
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Notes - 2009
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2009 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337).
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

a. Last Year's Accomplishments
The DMH, Office of Suicide Prevention (OSP) provides suicide hotline referrals in Spanish and English, a link to the California Strategic Plan on Suicide Prevention, and general information and fact sheets on suicide. CDE publishes an extensive list of youth suicide prevention resources on its Web site. CIPPP provides regional data (hospital discharges, fatalities, and now ED visits) on youth self-harming behavior to LHJs. Local school districts and parent teacher organizations have distributed summaries of research on suicide and self-harm selected from journals of several fields (e.g., anthropology, behavioral sciences, civil engineering, criminology, medicine, nursing,

social work, sociology.)). CIPPP continues to work with AAP-CA, the California Academy of Family Physicians, and members of the American Academy of Child and Adolescent Psychiatrists to provide summaries of recent research on the occurrence and prevention of child and adolescent self-harming behaviors. Improving mental health among adolescents and decreasing substance use in the MCAH population is one of the priorities that California identified in its 2010 Needs Assessment Local MCAH Programs work with local collaboratives to address adolescent health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention. Many of the LHJs have implemented the 4 P's Plus Program by training local providers to screen and provide brief interventions for clients at risk for tobacco, alcohol and other drug use. CPSP and AFLP programs in the LHJs assess and refer teens at risk for evaluation and treatment when appropriate. Under a contract with MCAH, the California Adolescent Health Collaborative (CAHC) reviewed adolescent health indicators, including suicide rates, and developed a statewide profile that identified "hot spots" (jurisdictions with poor health indicators) and "cold spots" (jurisdictions with good health indicators and effective adolescent health programs). CAHC developed a tool for LHJs to use in assessing local community support for positive youth outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention, including youth suicide.				X
2. AFLP case managers refer adolescent clients with suicide risk and other mental health problems to needed mental health services.		X		
3. AFLP case management strategies include both youth development and risk reduction activities and services		X		
4. MCAH works with the Adolescent Health Collaborative and other key partners to promote best practices in mental health and suicide prevention. This includes particular attention to the foster youth population.				X
5. Local MCAH Programs work with local collaboratives to address Adolescent Health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention.				X
6. Local MCAH Programs screen clients for signs of depression.			X	
7. The Department of Education authorizes school districts to use a portion of their Professional Development Block Grant funding to pay for suicide prevention training for school teachers				X
8. The Department of Mental Health administers grants to local programs under the Mental Health Services Act (MHSA). Local programs provide direct services.	X	X	X	X
9.				
10.				

b. Current Activities

DMH will no longer have direct oversight of local MHSA, as a result of 2011 legislation (AB 100, Statues of 2011) that moves oversight to counties, but it continues to further the California Strategic Plan on Suicide Prevention. OSP will continue to serve as a statewide resource on suicide prevention. MCAH continues to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer youth at risk for suicide to appropriate assessment and treatment. MCAH collaborates to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service

delivery. MCAH promotes provider screening, education, and referral to treatment and services for adolescence at risk of substance youth, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of adolescents. CIPPP provides regional summaries of data on the occurrence of self-harming behavior among youth, through data reports and the SafetyLit Weekly Update.

Humboldt County, with a 2010 suicide rate of 24.8 per 100,000 is working to end stigma and help individuals learn to cope with suicidal people by providing trainings on how to connect someone at risk with mental health services and to prevent suicide deaths by teaching people about the warning signs of suicide.

c. Plan for the Coming Year

As requested by LHJs, DMH OSP will continue to assist counties in implementing the MHSA, as well as ensuring the appropriate implementation of the four strategic directions listed on the California Plan on Suicide Prevention. MCAH will continue to work with CAHC and others to promote best practices in mental health and to investigate best practices in suicide prevention, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries, such as develop additional strategies for evaluating suicide prevention interventions; establish mechanisms for state- and local-interagency collaboration to improve monitoring systems for suicide and suicidal behaviors. MCAH will continue to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer adolescents at risk for suicide to appropriate assessment and treatment. MCAH will work to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH will also continue to promote providers' screening, assessment, education, and referral to treatment and services for adolescent clients at risk of alcohol use, drug abuse.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	67.2	67.5	67.8	68.1	78.6
Annual Indicator	67.3	73.8	75.9	75.6	75.6
Numerator	4577	4641	4618	4379	
Denominator	6800	6288	6083	5790	
Data Source		CA Birth Statistical Master File 2008; CCS, 2008	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of					

events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	78.6	78.6	78.6	78.6	78.6

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: State of California, Department of Public Health, Center for Health Statistics, 2010 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2010.

Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2010 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2009 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2009.

Tabulations by place of occurrence were done by the MCAH Program. Data exclude births with unknown birthweight or births weighing <227g or >8165g. For 2009 calculations, MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2009 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

a. Last Year's Accomplishments
NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 75.6 percent in 2009. This was an improvement from the 73.8 percent in 2008, but still far short of the Healthy People 2010 objective of 90 percent. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2009, Native American/ Alaska Native had the lowest percentages of these VLBW deliveries at NICU facilities at 73.1 percent. Pacific Islanders had the highest percent (79.4), followed by Asians (76.9), African Americans (74.8), and Whites (74.5).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. For 2010, there were 128 CCS-approved NICUs in California; however, not all facilities providing care for VLBW infants seek certification by CCS. Fourteen RPPCs provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPCs develop communication networks on many perinatal topics, disseminate education materials including toolkits, assist hospitals with data collection for quality improvement, and provide hospital linkages to CPeTS.

MCAH has two data projects which monitor perinatal outcomes: IPODR (http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx) and the California Perinatal Profiles (http://perinatalprofiles.berkeley.edu/). The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital-specific) data to aid quality improvement in maternity hospitals in California.

Efforts continue to improve data collected from birth certificates. Since 2004, OVR has collaborated with MCAH working with RPPC leaders to plan and present a statewide series of birth data quality trainings. The interactive presentations include discussions of difficulties in data collection, and explanations of medical terminology including illnesses, complications and procedures of labor and delivery. Twelve recently developed fact sheets from the Birth Defects Monitoring Program have been included in the training packets. Awards for excellence and improvement in data collection have been presented to hospitals.

MOD collaborated with RPPC and LHJs to implement the Preterm Labor Assessment Toolkit in 30 California hospitals, triaging women with suspected preterm labor. The importance of perinatal emergency preparedness continues to be an active topic and RPPC Region 4 selected this as its annual quality improvement topic.

CMS continues to collaborate with CPQCC to develop a plan to monitor outcomes of infants/children, 0-3 years of age in the recently restructured HRIF Program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, will allow the assessment of infant outcomes in association with perinatal/neonatal care.

MCAH, in collaboration with CPQCC and CPeTS, continues to implement an electronic data system to allow tracking of neonatal transports and monitoring of outcomes. This web-based perinatal transport data collection system helps to identify data elements to guide perinatal transport quality improvement.

CPeTS held two regional trainings in 2010 and plans to develop an on-line training system.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The fourteen RPPC provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.				X
2. The CA Perinatal Transport Systems (CPeTS) assist in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS-approved NICUs, updated daily, on the CPeTS website.		X		
3. RPPC and CPeTS assist hospitals with data collection and quality improvement activities.				X
4. MCAH shares information with and the Emergency Preparedness Office (EPO) regarding Perinatal Disaster Preparedness.				X
5. The CPQCC reports on neonatal care for hospital/NICU members of CPQCC, provide to CCS a useful and uniform reporting scheme for comparative assessment of hospitals on levels of care for neonates.				X
6. The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles and other reports, provide				X

information for health planning and allocation decisions, as well as evaluation of these decisions.				
7. MCAH and OVR collaborate to improve birth data quality by developing and convening a series of trainings with the assistance of RPPC regional leaders to Improve Data Quality on the California Birth Certificate.				X
8. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital-specific) data to aid continuous quality improvement in maternity hospitals.				X
9. RPPC regional cooperative transport agreements are based on the toolkit developed by RPPC and CMS, which includes policy development, outreach education, and review of outcome data to assist hospitals with transfer/transport agreements.				X
10.				

b. Current Activities
RPPC and CPeTS continue matching high-risk patients with the appropriate level of care. RPPCs review birth outcomes data, Perinatal Profiles, and transport agreements with hospitals during site visits.

All CCS approved NICUs are required to submit data annually, and CPQCC continues to retrieve and analyze NICU data. There were 129 CPQCC member hospitals in 2011. The 2010 CPQCC dataset included 12,000 "Big Babies" (>1500 grams), 7,000 "Small Babies" (<1500 gram), and approximately 7,000 acute transports. The CPQCC databases have expanded and include: 1) Vermont Oxford Network Small Baby <1500 grams; 2) CPQCC High-Acuity, Big Baby 3) All-California Neonatal Transport Database; 4) All-California, Rapid-Cycle Maternal/Infant Database, including Census, Birth Certificate and OSHPD Hospital Discharge data linked to CPQCC outcomes, and 5) HRIF dataset which follows eligible infants 0-3 years of age.

RPPC, with OVR, is providing eight trainings beginning in March 2011, emphasizing the importance of hospital administration, nurses, and birth clerks working collaboratively to accurately report birth data. MCAH is working with OVR to capture more complete information on complications/procedures of pregnancy and complications/procedures of labor and delivery on the birth certificate.

c. Plan for the Coming Year
RPPC and CPeTS continue their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer.

CMS and CPQCC will continue to respond to member questions, analyze data for CCS-approved NICUs, and address outliers and concerns about quality of care. RPPC, with OVR, will continue to present 8 Birth Data Trainings emphasizing administration, nurses, and birth clerks collaborating to obtain and accurately report birth data in 2012. RPPC regional leaders continue to explore opportunities for nursing staff to work with birth clerks for enhanced birth data reporting in continuing efforts to improve data quality.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	86.7	86.9	87.1	87.3	86.8
Annual Indicator	82.9	82.4	82.9	83.5	83.5
Numerator	459175	445108	428449	416759	
Denominator	554107	539978	516879	499218	
Data Source		CA Birth Statistical Master File, 2008	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	86.8	86.8	86.8	86.8	86.8

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: State of California, Department of Public Health, Center for Health Statistics, 2010 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2009 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

a. Last Year's Accomplishments
Between 2005 and 2008, NPM 18 had steadily decreased from 86.6 percent to 82.4 percent. In 2009, NPM 18 increased slightly to 82.9 percent. In 2010, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester increased again to 83.5 percent. Asians and Whites met the statewide annual objective for 2010 at 88.0 percent and 87.6 percent, respectively. Asians were more likely to receive prenatal care in the first trimester than women who were White, Hispanic (81.0 percent), African American (78.2 percent), AI (69.6 Percent) or Pacific Islander (68.1 percent).

CPSP, AFLP, BIH, WIC, American Indian Infant Health Initiative (AIIHI) and local MCAH

continued to provide case management services and linkages to medical care for their target populations. CPSP provides perinatal support services to approximately 165,000 women a year, and approximately 1500 providers receive a higher reimbursement rate for offering additional health education, nutrition, and psychosocial support services. CPSP providers receive a bonus for providing prenatal care in the first trimester.

PHCC's EveryWomanCalifornia website provides information to consumers about the importance of being healthy before pregnancy. It also focuses on the importance of planning for pregnancy and emphasizes early entry to prenatal care. PHCC continued to develop the MOD/ACOG postpartum project which will help clinicians to provide information and counseling to clients about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for women with chronic medical conditions.

MCAH provided ethnically diverse staff for recruiting clients into care, and LHJs employed a variety of methods to target diverse populations. MCAH provided a local toll free line for residents to obtain referrals to low cost health insurance and prenatal care. In addition, each jurisdiction delivered outreach in a way appropriate to their population's needs.

About 40 percent of all births in California are unintended. [47] Family PACT provided no-cost family planning services to all California residents with incomes at or below 200 percent FPL, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to more timely prenatal care, since women with planned pregnancies seek care earlier.

The AIM Program administered by MRMIB provided low-cost coverage for over 7000 pregnant women with incomes from 201-300% FPL.
In spite of efforts to increase first trimester prenatal care, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, economic downturn leading to more uninsured reproductive age women and high rates of unintended pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CPSP provides Medi-Cal eligible women with prenatal care and support services (health education, nutrition services, and psychosocial support.	X	X	X	X
2. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and provides a comprehensive approach to access and maintain health care services, provide social support and empowerment strategies.		X	X	X
3. AFLP provides case management services to pregnant adolescents at-risk for poor birth outcomes. AFLP is researching evidence-based strategies and expanding case management services by promoting the concept of Positive Youth Development (PYD), which		X	X	
4. AIIHI serves prenatal and parenting AI women with direct health care services and case management services.	X	X		
5. MCAH works to provide ethnically diverse staff for recruiting clients into care, and LHJs employ a variety of methods to target diverse populations.		X	X	X
6. Family PACT Program provides no-cost family planning services to low-income residents; these services help to reduce the rate of unintended pregnancy, and contribute indirectly to	X			X

increased utilization of prenatal care.				
7. PHCC plays a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities.			X	X
8. The AIM program provides low-cost health coverage to pregnant women who don't have adequate health insurance and whose income is too high for no-cost Medi-Cal.. Their newborns may be covered by the Healthy Families Program.		X		
9.				
10.				

b. Current Activities

CPSP provides comprehensive services, including routine obstetric care, nutrition, health education, and psychosocial services. Providers receive a bonus for each woman receiving an initial combined assessment and the initial office visit within 4 weeks of entry into care. MCAH works collaboratively with MCMC to ensure that CPSP is offered to enrolled pregnant women as required by law.

Family PACT provides no-cost family planning services to all California residents with incomes at or below 200 percent of the FPL. AIM provides low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

PHCC released the MOD/ACOG Interconception Care Project of California Guidelines in October 2011 to help clinicians provide client counseling about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for high risk women with chronic medical conditions.

AFLP provides case management services to at-risk pregnant and parenting teens. AFLP is researching evidence-based strategies and expanding case management services by promoting the concept of Positive Youth Development (PYD), which includes reproductive life planning. BIH, which targets at-risk African American pregnant and parenting women, is implementing the new group intervention model.
LHJs continue outreach to pregnant women and assist with referrals and enrollment in Medi-Cal and other health plans.

c. Plan for the Coming Year

MCAH will continue to work with LHJs to improve outreach to women of childbearing age and pregnant women and provide linkages to early prenatal care.

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

CPSP plans include expanding provider trainings to include a web-based provider overview training and providing local data on CPSP billing patterns to evaluate local CPSP programs. Local CPSP coordinators will continue provider recruitment. Coordinators will strengthen utilization of the CPSP scope of benefits by training providers in documentation, program services, development of materials and evaluative reports on the efficacy of services. MCAH and LHJs undertake these activities to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care. MCAH is working to consolidate data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH will continue to work closely with MCMC to facilitate all pregnant women receive CPSP services.

AFLP will continue to implement the Positive Youth Development component into existing services.

LHJs with BIH will continue to implement the new group intervention, as well as the case management component, in order to improve the health and social conditions for African-American women and their families.

D. State Performance Measures

State Performance Measure 1: *The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					0
Annual Indicator				0.0	0.0
Numerator				0	0
Denominator				1	1
Data Source				Pilot Programs Data, CMSNet	Pilot Programs Data, CMSNet
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	30	40	40	40	40

Notes - 2010
This measure is the percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system. This is a new measure from the 2010 Needs Assessment. The 1115 Federal Waiver CCS Pilot Programs will begin January 2012 so there will be no data for this measure until 2013 for CY 2012.

The numerator is the number of children birth to 21 years enrolled in the CCS program who are also enrolled in a specified pilot program. The denominator is the number of children birth to 21 years enrolled in the CCS program with open cases.

a. Last Year's Accomplishments
Bridge to Reform waiver planning continued. Five demonstration project sites were selected with 4 different models of care through which CCS children will have all their care needs met through a single coordinated health system. The models are 1. Utilization of MCMC Plans, Specialty Health Care Plan (SHCP), Enhanced Primary Care Case Management (EPCCM), Provider-based Accountable Care Organization (ACO). These innovate models have projected phase in start dates anticipated for late 2012 through 2013.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Convened Stakeholder Group to help determine components of Pilot Program Models				X
2. Draft RFP to request Pilot Program Proposals				X
3. Select Pilot Programs				X

4. Implement Pilot Programs	X			
5. Monitor and Evaluate Pilot Programs	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The 1115 Evaluation Oversight Committee is a multidisciplinary team of key internal CCS leaders and Medical Consultants, plus representation from various stakeholders groups representing facilities, providers and family advocacy groups. The actual evaluation program is being developed by UCLA Center of Health Policy Research and will include a "dashboard" for rapid determination of any areas which require more attention, and extensive family/providers satisfaction to access, integration of care, and identify barriers to reform.

c. Plan for the Coming Year
1) These innovate models have projected phase in start dates anticipated for late 2012 through 2013 Goal to enroll children January 1, 2012
2) The 1115 Evaluation Oversight Committee is a multidisciplinary team of key internal CCS leaders and Medical Consultants, plus representation from various stakeholders groups representing facilities, providers and family advocacy groups.
3) Pilot Project Data analysis by UCLA Center for Health Policy Research and UCSF Philip R Lee Institute for Health Policy Studies.

4) Rate analysis by Mercer (Actuary)

5) Existing coordinated systems in CA include Kaiser and UC. With Kaiser, CCS has recently approved 2 tertiary care centers within the Kaiser system, but there is no data at this time on the CCS population served. Within the University of California system, there are varying levels of integration of care. CCS will be developing systems to collect this data within the next year.

State Performance Measure 3: *The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					0
Annual Indicator				0.0	0.0
Numerator				0	0
Denominator				1	1
Data Source				On-line Survey and CCS County programs	On-line Survey and CCS County programs
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	50	55	55	55

Notes - 2010
This measure is the percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. This is a new measure from the 2010 Needs Assessment. No data will be available until 2013

The numerator is the number of families randomly selected by region who complete a satisfaction survey. The denominator is the number of families randomly selected by region to complete a satisfaction survey.

The Title V 2010 Needs Assessment CCS stakeholder group identified several priority objectives whereby successful implementation can be assessed through a family satisfaction survey. These include: define and implement medical homes; increase family partnership in decision making and satisfaction with services; link families to information and support; and conduct regular assessments of the level of parent/patient satisfaction as part of CCS outcomes. The CCS program cannot directly measure whether children enrolled in CCS are receiving their primary care in a medical home. However, through a family satisfaction survey, CCS can attempt to assess through specific questions whether children are receiving care in a medical home. This measure also allows the CCS program to evaluate family satisfaction as changes are made to the CCS program over the next 5 years.

a. Last Year's Accomplishments
SPM 03 is the percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. The Pilot evaluation group has been meeting bimonthly to discuss development of an appropriate survey for the CCS Pilots.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand potential base of surveys (from 1115 Waiver's CCS Pilot Projects) including with evaluations to assess satisfaction of families enrolled and not enrolled				X
2. Work with 1115 Waiver CCS Stakeholder Group to develop family survey				X
3. Utilize translation services to translate surveys into most frequently used languages for the region				X
4. Work with Regional Office Staff and local programs to administer the surveys				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Developing a plan to utilize 1115 Waiver's CCS Pilot Projects' Evaluation Oversight Group and their work on a family survey to administer to CCS families enrolled and not enrolled in the Pilot Projects. Some of the clients not enrolled will be selected to be part of the control population. This method will result in not duplicating work already planned for the coming years.

c. Plan for the Coming Year

1) Expand potential base of surveys (from 1115 Waiver's CCS Pilot Projects) including with evaluations to assess satisfaction of families enrolled and not enrolled
2) Utilize translation services to translate surveys into most frequently used languages for the region
3) Work with Regional Office Staff and local programs to administer the surveys.

State Performance Measure 4: *The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					12.7
Annual Indicator			13.4	15.0	15
Numerator			68828	74243	
Denominator			513143	495981	
Data Source			MIHA	MIHA	MIHA
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.7	12.7	12.7	12.7	12.7

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: 2010 Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past 2 years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2010.

Notes - 2009
Source: 2009 Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past 2 years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2009.

a. Last Year's Accomplishments
SPM 04 is the percent of women with a recent live birth that reported binge drinking during the three months prior to pregnancy. In 2010, 15 percent of mothers with a recent live birth reported binge drinking during the three months prior to pregnancy, an increase from 13.4% in 2009. This rate differed by racial and ethnic group. White women (20.5%) were most likely to binge drink

during the three months prior to pregnancy, followed by Hispanic (12.6%), Asian/Pacific Islander (12.0%) and African American women (10.7%). An estimated 4,460 to 6,050 babies with FASD are born each year in California. [65, 66]

FASD describes the range of effects in individuals whose mothers used alcohol during pregnancy, including physical, cognitive, behavioral and learning difficulties with lifelong implications. MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services.

MCAH promotes preconception health, of which alcohol use prevention in women of reproductive age is a key feature. MCAH participates in PHCC, providing information, tools and resources for communities on the importance of optimal health for women before pregnancy. PHCC developed educational materials informing women of the risk of unintended pregnancy associated with alcohol use. The PHCC website has valuable information on perinatal substance use prevention..

MCAH participates in the FASD Task Force comprised of state/local agency representatives. An FASD Task Force website has been developed to complement its work on increasing legislators' awareness of FASD. The FASD Task Force continues to work on bringing more prominence to the annual celebration of FASD Awareness Day on Sept. 9, 2010. It partnered with DSS to produce an educational brochure on alcohol use prevention targeted to youth.

ADP reconvened the SIT Alcohol and Other Drug Workgroup, with members from DMH, DSS, DDS, CDCR, Administrative Office of the Courts, ADP and MCAH in April 2009 to address FASD prevention. It completed two projects in April 2010: a matrix of members' programs impacting FASD and FASD fact sheets tailored for each agency's specific use. MCAH participated in the SIT ADP Workgroup. The MCAH-specific FASD fact sheet was released on the MCAH website on September 7, 2010.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Community-based prevention and support programs, including AFLP, BIH, CPSP and CDAPP, educate clients about the dangers of alcohol use during pregnancy and refer high-risk women for alcohol treatment services.		X		
2. MCAH participates in the statewide FASD Task Force and the SIT ADP Workgroup.				X
3. LHJs conduct prenatal substance use screening programs, with several using the 4-Ps Plus model.				X
4. Santa Cruz County Public Health nurses provide home-based support, education, and professional assistance for families with premature and/or substance exposed babies, or mothers with mental health issues.		X		
5. PHCC continues to augment and monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women of reproductive age.				X
6. Alameda County continues to implement the Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological and physical problems.				X
7.				
8.				

9.				
10.				

b. Current Activities
LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use based on evidence-based models and focusing on alcohol use during pregnancy in their presentations to providers and other interest groups.

Alameda County continues to implement their Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological, and physical problems.

PHCC continues to monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women. MCAH programs and initiatives all feature components to stress importance of abstaining from alcohol if you are or may become pregnant and provide resources to help. In evaluating the messaging, focus group testing suggested that the idea of abstaining from alcohol during your reproductive years because of the risk of prenatal alcohol exposure was viewed as too conservative by many women. As such, the PHCC revised its EVERYDAY mnemonic recommendation from "Avoid tobacco, drugs and risky drinking" to "Avoid tobacco, alcohol and drugs. Or, use birth control until you can." This message was consistent with our harm reduction philosophy of behavioral intervention.

c. Plan for the Coming Year
LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the FASD Task Force and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website. Preconception Peer Educators at California Community Colleges and Universities will partner with LHJs and local organizations to conduct campus and community outreach to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure. MCAH will publish a MCAH bulletin highlighting the recent developments in preconception alcohol research and data trends.

State Performance Measure 5: *The percent of cesarean births among low-risk women giving birth for the first time.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					25.1
Annual Indicator		26.3	26.6	26.1	26.1
Numerator		43021	42603	40713	
Denominator		163355	160307	156112	
Data Source		CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File

Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25.1	25.1	25.1	25.1	25.1

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: 2010 Birth Statistical Master File, MCAH Program, California Department of Public Health. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2010. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).
Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

Notes - 2009
Source: 2009 Birth Statistical Master File, MCAH Program, California Department of Public Health. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2009.

Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

a. Last Year's Accomplishments
Over the decades, cesarean rates have increased dramatically in California. In 2010, C-section births among low risk women giving birth for the first time were at 26.1%. The causes for the rise in cesarean section are not clear, but may be associated with rising rates of pre-existing maternal morbidities such as obesity, as well as rising rates of labor induction and augmentation. Some have suggested that obstetricians might be giving up on vaginal deliveries and switching to C-sections earlier in labor than they used to, or that more women are requesting C-sections so they can have greater control over when their babies are born. To explore the multifaceted contributors to cesarean delivery, MCAH funded the Maternal Quality Indicators Collaborative with UCLA to assess current levels of maternal morbidity in California and develop valid indicators to measure trends in maternal outcomes and funded the CMQCC to improve California maternity care through data driven quality improvement efforts. MQI completed a trend analysis of cesarean deliveries in California with the UCLA Maternal Quality Care Collaborative and found a significant rise in cesarean deliveries between 1999 and 2005. Of note, this rise in cesarean deliveries also corresponded to a rise in maternal morbidity due to infection and a rise in maternal mortality overall. CMQCC conducted a geographic analysis of cesarean deliveries in California and found wide variation in the cesarean rates between counties in the north and counties in the south, suggesting differences in obstetrical practices by region.

As a result of the previous work, CMQCC developed and disseminated a toolkit to reduce non-medically indicated labor induction and cesarean section prior to 39 weeks gestational age. MCAH has also collaborated with MOD to publish and disseminate the toolkit throughout the state. The toolkit provides guidelines to hospitals and materials for patient education.

MCAH also funded a Local Assistance for Maternal Health project in San Bernardino to help the county health department provide leadership to local hospitals to implement quality improvement activities to reduce elective inductions of labor. Fourteen hospitals In San Bernardino County

participated and implemented new policies and procedures to reduce elective inductions. Process and health outcomes measures are being tracked and while induction rates are decreasing, augmentation rates are rising. The concern is that definitions of labor may be confounding data collection.

MQI and CMQCC provided expertise and support for development of new obstetrical measures for the National Quality Forum which were then incorporated by the Joint Commission.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate and assess impact of state toolkit: "Elimination of Non-Medically Indicated Induction of Labor before 39 Weeks Gestation"		X		
2. Support Local Assistance for Maternal Health to implement toolkit strategies at hospitals at the local level	X			
3. Support Local Assistance for Maternal Health to promote patient education regarding the value of waiting until 39 weeks to deliver			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

L.A. County is conducting a county-wide campaign to reduce cesarean deliveries. CMQCC is working with UCSF to study racial disparities in cesarean deliveries in the state and provided technical assistance to two local health departments who are addressing maternity care issues and to the Regional Perinatal Programs of California. CMQCC published a "white paper" on cesarean deliveries that outlined marked regional variation in surgical deliveries. San Bernardino County LAMH worked to reduce non-medically indicated induction of labor by educating the community about labor induction and promoting best practices among clinicians and providers. Their efforts included labor induction guidelines and recommendations for local area hospitals to follow when scheduling labor inductions; patient consent document to inform patients of options; and, an Advisory Council comprised of public and private organizations Fourteen hospitals in San Bernardino participate in the project and are regularly involved in webinars and data sharing. Outcome data will be analyzed by the local health department before the project ends in June 2012. MQI trended and composed a manuscript describing the level of medical indication associated with induction and preterm delivery; this knowledge is central to standardizing medical interventions that may reduce cesarean delivery.The PHCC and MCAH Preconception Health and Nutrition and Physical Activity Initiatives conducted activities to address many of the preco

c. Plan for the Coming Year

MQI will undertake a research project to increase our understanding of the relationship between rising prevalence of cesarean delivery and maternal morbidity. This will involve estimating the contribution of preconception, pregnancy-related, and obstetric maternal morbidity to Nulliparous, Term, Singleton, and Vortex (NTSV) cesarean deliveries and to also estimate the contribution of NTSV cesarean delivery to postpartum maternal morbidities and repeat cesarean delivery. MQI will also continue to monitor maternal morbidity trends in California and begin exploring their

associated costs.

LAMH will report on program and health outcomes regarding reduction of elective early term deliveries and share implementation guidelines for both projects and share with local MCAH directors. The LAMH project funding ends in June 2012, however if funding becomes available, other topics of interest to address are improving quality of care measures to address increasing maternal morbidity and a rising trend in rates of cesarean birth.

CMQCC will continue to provide technical assistance to local and regional maternal health efforts related to cesarean delivery.

State Performance Measure 6: *The percent of women of reproductive age who are obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					21.7
Annual Indicator		21.6	21.8	20.9	20.9
Numerator		1290393	1299520	1205673	
Denominator		5987671	5954750	5764922	
Data Source		Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	21.7	21.7	21.7	21.7	21.7

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: 2010 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Numerator and denominator are weighted to the representative number of resident women in the state and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 should be not compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2007 =19.3; 2008 =20.9; 2009 =19.7.

Notes - 2009
Source: 2009 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI)

greater than or equal to 30 kilograms body weight/ body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Numerator and denominator are weighted to the representative number of resident women in the state and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information).

a. Last Year's Accomplishments

There has been an upward trend in obesity among women of reproductive age over the past ten years. In 2000, 16.5% of women of reproductive age were obese (BMI = 30 kg/m2), compared to 20.9% in 2010. African American (39.0%) and Hispanic (27.7%) women were more likely to be obese than White (18.2%) women.
MCAH promoted obesity reduction and healthy strategies to achieve optimal preconception weight,, prenatal weight gain, and breastfeeding.

MCAH and CMS participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs. MCAH and CMS collaborate with the California Obesity Prevention Program (COPP) and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity.

MCAH was involved in planning the California Childhood Obesity Conference which emphasized the life course perspective, focusing on the role of childhood weight gain in adult obesity.

MCAH worked on CDAPP, AFLP and CPSP program nutrition and physical activity guidelines.

MCAH was involved in developing the Health in All Policies Task Force report which has specific nutrition and physical activity recommended policies, programs, and strategies that can be implemented in the State.

PHCC Interconception Care Project of California in coordination with ACOG District IX and MOD began work on the provider guidelines for the post-partum visit, which include weight management for women with gestational diabetes.

The PHCC's web-based fact sheets on topics related to preconception health, such as healthy weight, healthy food choices and physical activity were made available in Spanish via www.cadamujercadadia.org.

MCAH developed a preconception health social marketing campaign using First Time Motherhood grant funds. The Latina component consisted of radio messages on preconception folic acid consumption and directed listeners to www.cadamujercadadia.org. The African American and youth components featured nutrition, physical activity and weight as part of overall health.

MCAH monitored pre-pregnant weight status and pregnancy weight gain utilizing birth certificate and MIHA Survey data, and considers obesity in risk factor analysis for the Pregnancy-Associated Mortality Review.

MCAH LHJs supported state efforts. Alameda provided information on the problem of obesity in women of child-bearing age to health care providers and public health staff including strategies for patient education and behavior change. Exercise and nutrition classes were provided to promote nutrition, exercise and wellness. Technical support was given to CPSP nutritionists, regarding CPSP and Steps to Take nutrition resources, prenatal weight gain grids, dietary assessment tools, identification of high risk prenatal clients and gestational diabetes testing and referral. A nutritionist provided information on the problem of obesity in women of child-bearing age to health care providers and public health staff including strategies for patient education and behavior change. A Healthy Weight Workgroup was convened with community partners to

address the goal of decreasing overweight and obesity in women of child-bearing age.

Contra Costa conducted a Healthy Living, Healthy Eating Fair to educate attendees about proper nutrition to prevent diabetes, high blood pressure, cholesterol, and weight gain. Fresno providers were given new nutrition assessment forms and instructions on how to calculate BMI for pregnant and postpartum mothers Kern collects BMI data, emphasizes the importance of nutrition assessments and reassessments to identify weight issues and to use CPSP material to educate clients on controlling weight gain during pregnancy. Long Beach a wellness forum established for African American churches to promote healthy food choices.

A curriculum and materials that were developed by Sonoma as part of the Healthy Weight in Women Action Learning Collaborative was shared with community organizations developing teen cooking classes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				X
2. BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity.		X		
3. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent obesity.				X
4. BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
5. MCAH Offered MCAH LHJs a “Here is Where Healthy Starts” award for policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X
6. MCAH and CMS collaborate with the California Obesity Prevention Program (COPP) the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X
7.				
8.				
9.				
10.				

b. Current Activities
MCAH collaborated with state programs and agencies, advocates, experts and local MCAH directors to prevent overweight among women of childbearing age.

MCAH continue to integrate obesity prevention into CDPH programs through OPG, developed a web page entitled "Healthy Weight Among Women of Reproductive Age" and collaborated with FHOP to develop and present a Webinar and Fact Sheet on Healthy Weight.

The MCAH adolescent cookbook in English and Spanish was published. which includes seasonal food variation and physical activity recommendations.

MCAH researched and identified potential nutrition, physical activity and breastfeeding

benchmarks for the California Home Visiting Program (CHVP).

The PHCC Interconception Care Project of California provider guidelines and patient handouts, which include postpartum obesity management were finalized and publicized.

MCAH finalized new information on model nutrition, physical activity, and breastfeeding to publish the MyPlate for Moms/My Nutrition Plan for Moms, Adolescent Nutrition and Physical Activity Guidelines for AFLP, CDAPP Guidelines for Care, and the CPSP Steps to Take Guidelines. The 24-hour dietary recall form was updated to mirror the new MyPlate materials. BIH and local MCAH LHJs used the resources to prioritize optimal nutrition and physical activity.

MCAH and CDC staff completed a manuscript assessing the contribution of pre-pregnancy overweight/obesity to gestational diabetes among California women giving birth in 2007-2009.

c. Plan for the Coming Year

MCAH will continue to collaborate with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among women of childbearing age. MCAH will continue to participate and collaborate on OPG, which aims to integrate obesity prevention into CDPH programs and develop an action plan and obesity-related proposals for funding opportunities.

MCAH is updating CDAPP, CPSP, BIH, and AFLP nutrition and physical activity guidelines and will finish the revision of an adolescent cookbook. in English and Spanish. MCAH will finalize the Adolescent Nutrition and Physical Activity Guidelines for AFLP and post on the web with various access points, including preconception, AFLP and the nutrition/physical activity web pages. Revised CDAPP Guidelines for Care and the CPSP Steps to Take Guidelines will be finalized to include new information on model nutrition, physical activity, breastfeeding resources and interventions. BIH and local MCAH LHJs continue to prioritize optimal nutrition and physical activity as important interventions to reduce obesity in women of childbearing age.

Options for substituting seasonal fruits and vegetables and recommendations for physical activity will be included. Recipes will be coordinated with ingredients available through the new WIC food package.

MCAH will investigate leveraging existing campaigns to include preconception messaging, such as the 50 million pound challenge (sponsored by State Farm) and the President's Council on Physical Fitness. Also, MCAH will investigate building linkages with existing nutrition resources, such as community garden programs, famer's markets and diet support programs. Feasibility of new campaigns, such as a "Biggest Loser" spin-off geared toward women of reproductive age with incentives and rewards coming from community and corporate partners with a vested interest in promoting weight loss will be considered. MCAH will also consider expanding partnerships with organizations such as UC Davis.

Per recommendations by the IOM's Committee to Reexamine IOM Pregnancy Weight Guidelines (2009),MCAH will continue to conduct routine surveillance of pre-pregnancy BMI, weight gain during pregnancy and postpartum weight retention and report the results by age, racial/ethnic group, and socioeconomic status to inform local initiatives to promote healthy weight.

MCAH will continue to inform women of the importance of conceiving at a normal BMI as part of our preconception initiative, encourage a higher proportion of women to limit their weight gain during pregnancy based on the revised IOM guidelines and post those on the MCAH website.

MCAH programs will offer counseling, such as guidance on dietary intake and physical activity, which is tailored to client circumstances.

State Performance Measure 7: *The percent of women whose live birth occurred less than 24 months after a prior birth*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					11.7
Annual Indicator		13.2	12.9	12.3	12.3
Numerator		71683	66674	61798	
Denominator		542684	518167	501837	
Data Source		CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11.7	11.7	11.7	11.7	11.7

Notes - 2011
A manual indicator is reported for 2011 based on 2010.

Notes - 2010
Source: State of California, Department of Public Health, Center for Health Statistics, 2010 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2009 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.

a. Last Year's Accomplishments
Between 2008 and 2010, NPM 7 steadily decreased from 13.2 percent to 12.3 percent. Among the largest race/ethnic groups, African American women were most likely to have a live birth less than 24 months after a prior birth (13.8 percent), followed by Hispanics (12.5 percent), Whites (12.2 percent) and Asians (10.4 percent).

Preconception and interconception care is a priority for the MCAH Program. The Preconception Health Initiative (PHI) aims to improve the health of women prior to pregnancy to improve birth outcomes and reduce disparities in maternal and infant morbidity and mortality. A critical part of this initiative is adequate spacing between births. To reduce unintended pregnancy and appropriate birth spacing, MCAH and the Office of Family Planning (OFP) supported programs that help women and teens understand the importance of pregnancy timing, decrease risky health behaviors, increase access to and promote the use of effective contraceptive methods, and improve the effectiveness with which all methods are used. OFP programs include Family PACT, which provided no-cost family planning services to low-income men, women and teens, the Community Challenge Grant (CCG) and the I&E Program.

MCAH activities included active participation on the Preconception Health Council of California (PHCC), which plays a pivotal role in relaying the message of the importance of reproductive life planning (RLP), intended pregnancies, birth spacing and preconception care through stakeholders to local communities statewide. The PHCC preconception health website, www.everywomancalifornia.org, has resources for consumers and providers. In 2010, the PHCC website was expanded to include consumer handouts in Spanish. The project to develop clinical guidelines for the postpartum visit began in 2010. The guidelines included content to help providers address pregnancy spacing, care for chronic conditions between pregnancies and timely prenatal care for future pregnancies. .

MCAH also participated in ASHWG, which promotes an integrated system of reproductive health resources for youth to ensure access to family planning services in order to reduce the rate of unintended pregnancy. MCAH also coordinated AFLP which services pregnant and parenting teens with a goal reduce repeat births to teens and encourage the completion of secondary education.

MCAH programs including BIH, CPSP, CDAPP, and the PHI worked to integrate pregnancy timing and spacing messages into their content.

The BIH program model was revised to included 20 group sessions (ten prenatal and ten postpartum), addressing birth spacing and the importance of planning for a subsequent pregnancy to improve maternal and infant outcomes. In the final session, participants create a Life Plan that includes plans for future children and decisions about birth control methods.

CPSP guidelines assisted providers and practitioners with health education, nutrition, and psychosocial interventions and include information on family planning and adequate birth spacing. The health educator is also tasked with helping the patient develop a plan to achieve future reproductive goals.

MCAH began revising the toolkit for CDAPP providers to include family planning and contraception options for women with diabetes.

PHI implemented a social marketing campaign targeting African-American and Latina women and youth and features messages encouraging them to improve their health and plan for pregnancy to optimize outcomes for themselves and any children they may have.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH Program and OFP support several programs that help women avoid unintended pregnancy by decreasing risky behavior and increasing access to and promoting the use of effective contraceptive methods.				X
2. ASHWG works to promote and protect the sexual and reproductive health of California youth, which includes a focus on pregnancy prevention.				X
3. The PHHI supports organizations to increase birthing intervals, prevent unintended pregnancy and improve preconception health by providing best practices and networking opportunities.				X
4. The PHCC plays a pivotal role in relaying the message of the importance of reproductive life planning, pregnancy intendedness, birth spacing and preconception care to local communities.			X	

5. The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling to low-income Californians.	X			
6. AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children, including prevention of subsequent pregnancies.		X		
7. BIH incorporates discussion of contraception and pregnancy spacing into its case management, group sessions and health promotion activities.		X		
8. CPSP and CDAPP incorporate family planning and birth spacing in guidelines and educational materials.		X		
9.				
10.				

b. Current Activities
MCAH promoted appropriate pregnancy timing and birth spacing in programs and initiatives.

Family PACT, CCG, I&E, and AFLP continued their teen pregnancy prevention efforts. AFLP began the Positive Youth Development intervention centered on RLP to empower clients with goal setting and promote optimal birth spacing among teens.

The revised BIH model was piloted and revised in preparation for full program implementation.

The CDAPP program was restructured to emphasize the online resource center. The CDAPP toolkit, with an emphasis on preconception health and optimal birth spacing for women with diabetes, was published. CDAPP resources are also linked on the PHCC website.

The PHCC website was revised to include more interactive features and link to pages designed by PHI for targeted populations, such as Spanish-speaking women and African-American women. The clinical guidelines for the postpartum visit were finalized and disseminated online at www.everywomancalifornia.org/postpartumvisit. CPSP Services Coordinators were trained to use the Interconception Care Project postpartum visit guidelines with clients.

CFHC, a PHCC member, expanded the recently completed preconception health and reproductive life planning demonstration project to more Title X clinics and helped MCAH conduct focus groups with women about the concept of RLP.

c. Plan for the Coming Year
The MCAH Program will continue to strengthen and expand its interconception and reproductive life planning initiatives toward the aim of ensuring adequate birth spacing.

AFLP PYD sites will finish case-manager training and begin pilot testing the revised RLP client-centered intervention tool. Preliminary steps to align the programmatic goals of the Teen Pregnancy Prevention Program with the PHI RLP strategies will begin.

The PHCC will work with California universities and community colleges as well as LHJs to promote reproductive life planning and appropriate birth spacing through the Office of Minority Health Peer Preconception Educators Program (PPE). This program will train post-secondary students to create and support community outreach initiatives to address preconception and interconception health.

The PHCC preconception care guidelines will be released and published on the everywomancalifornia.org website to provide clinical guidance on the preconception well woman visit recommended by the IOM that will be included as a health exchange benefit by the HHS

preventive services for women. The PHCC will also continue to disseminate and conduct trainings on the Interconception Care Project of California for health care providers and public health professionals.

The California Home Visiting Program will promote appropriate pregnancy spacing with contraceptive education, counseling, and referral to clinical services beginning in the final trimester of pregnancy and extending throughout the postpartum period.

The CFHC will continue its efforts to expand its reproductive life planning demonstration project to all clients of Title X-funded clinics by 2015.

State Performance Measure 8: *The percent of public school students in 9th grade reporting a high level of school connectedness.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					43
Annual Indicator		40.4	42.0	43.2	43.2
Numerator		93225	102319	105767	
Denominator		230541	243896	244863	
Data Source		CA Healthy Kids Survey	CA Healthy Kids Survey	CA Healthy Kids Survey	CA Healthy Kids Survey
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	43	43	43	43	43

Notes - 2011
A manual indicator is reported for 2011 based on 2010 results.

Notes - 2010
Source: California Healthy Kids Survey (CHKS), 2007-09. Unpublished data provided by WestEd on March 22, 2012. CHKS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools.

Notes - 2009
Source: California Healthy Kids Survey (CHKS), 2007-09. Unpublished data provided by WestEd on July 1, 2011. CHKS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools.

a. Last Year's Accomplishments
MCAH reviewed the professional literature to develop health policy and programs that support school retention. Health is intimately connected with education in multiple ways across the life course. Education influences health through its impact on employment and associated determinants of health such as living conditions, access to healthy foods, safe communities and quality health services. Increased education also allows for the opportunity for better paying jobs. Furthermore, increased educational achievement improves MCAH outcomes through its impact on health knowledge and behaviors, as well as sense of control, social standing, and social

support.

Longitudinal research supports a broad school-connectedness measure: school connectedness was found to be the strongest protector against substance use, school absenteeism, early sexual initiation, violence, and risk of unintentional injury (such as drinking and driving or not wearing seat belts). Research highlights the protective effect that connectedness i.e. the emotional attachment and commitment a child makes to social relationships in the family, peer group, school, community, and culture has on adolescent sexual and reproductive health.

MCAH supports Positive Youth Development programs (PYD) as an effective public health response. These programs support the capacity and strength of youth. MCAH's AFLP is one health program that provides an opportunity to incorporate principles of positive youth development that build on strengthening protective factors that support education. By assisting adolescents in identifying important linkages to schools, MCAH AFLP can build on the education-health connection that leads to positive health outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH and its partners develop adolescent positive youth development principles that support adolescent school retention.				X
2. MCAH develops program and policy recommendations that support school completion.				X
3. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to support positive youth development in schools.				X
4. MCAH promotes interventions supported by a positive youth development framework.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCAH continues to work on developing a framework to integrate positive youth development in three ways: 1) the Adolescent Family Life Program; 2) CAHC, a statewide coalition of individuals and organizations, both public and private, whose main goal is to support adolescent health in California through trainings, data analysis, education, and TA to MCAH and to local MCAH programs; and, 3) ASHWG, comprised of program managers from the CDPH, including Office of AIDS, STD Control Branch, Office of Family Planning, and Maternal, Child and Adolescent Health), CDE, and key CBOs, including CAHC and the State Title X Administrator for California, the CFHC.

MCAH applied for and was awarded a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers funding opportunity from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. CDPH/MCAH received $2 million for federal project period 2010 -- 2013. Under this grant, using a positive youth development framework, MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its AFLP and the Cal-SAFE.

c. Plan for the Coming Year

MCAH will continue to collaborate with local AFLP and Cal-SAFE programs in each awarded LHJ to implement the AFLP PYD Program. AFLP PYD case management intervention services will be provided by the selected AFLP programs in partnership with Cal-SAFE sites that no longer have case management support services, but do continue to offer child and developmental services for the teens' children. AFLP PYD interventions will be strength-based and will be formed in client goals that support a life planning approach.

AFLP will implement this intervention at 11 AFLP sites that were identified a competitive process.

MCAH will utilize the expertise within CAHC to develop and refine the intervention, as well as train providers. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

State Performance Measure 9: *Low-income infant mortality rate.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					.
Annual Indicator			5.5	5.7	5.7
Numerator			1358		
Denominator			248705		
Data Source			Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	5.4	5.4	5.4	5.4	5.4

Notes - 2011
A manual indicator is reported for 2011 based on 2009.

Notes - 2010
A manual indicator is reported for 2010 based on 2009.

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 Linked Birth – Death Cohort File.

a. Last Year's Accomplishments
California uses the linked birth and death cohort files to report the infant mortality rate among low income women. The low income infant mortality rate was constant at 5.7 infants per 1000 from 2006 to 2008 and decreased to 5.5 in 2009.

Sixteen LHJs implement FIMR programs. In Contra Costa, preconception/interconception education has been integrated into the maternal interview, which is an essential component in the spectrum of case management and family support services offered to clients following a fetal or infant death. Given its size and large number of birthing hospitals, L.A. County uses a survey tool (L.A. Health Overview of a Pregnancy Event) to conduct FIMR. The survey questions are designed to focus on maternal behaviors and health system variables that can be addressed by public health interventions.

All MCAH LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance. Many LHJs integrate preconception and interconception messaging into their services as a strategy to prevent poor birth outcomes such as infant mortality.

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, work on improving infant health and birth outcomes and enroll mostly low-income women. CPSP aims to decrease the incidence of low birthweight (LBW<2500 grams) infants by providing at-risk women with comprehensive services including prenatal care, education, and psychosocial support. Over 1,500 Medi-Cal obstetrical practitioners provide CPSP services, serving approximately 165,000 women annually. A primary goal of AFLP is to improve birth outcomes for babies born to adolescent clients, many of whom receive Medi-Cal services. AFLP assists pregnant adolescents to access prenatal and other necessary health care early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born LBW in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.

MCAH and CMS collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes. CPQCC has 129 member hospitals, accounting for over 90 percent of newborns requiring critical care. RPPC provides consultation to delivery hospitals, using current outcomes data from Perinatal Profiles, and supports implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects and improve risk-appropriate care.

MCAH participates in PHCC, providing information, tools and resources to local communities on achieving optimal health for women prior to pregnancy. A social marketing campaign was conducted to foster folic acid use, reproductive life planning and self-respect. MCAH and CMS collaborated with MOD on its Prematurity Campaign , which aims to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. A statewide effort to reduce elective deliveries of less than 39 weeks gestational age is ongoing throughout the state through efforts with multiple stakeholders: MOD, ACOG, the California Hospital Association, and CMQCC with encouragement from RPPC.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of Maternal Child Health Programs, CityMatCH and National Healthy Start Association, which provided tools to
address infant mortality disparities. L.A. County created an Action Learning Collaborative (LAC ALC) website to provide information on resources and best practices relating to infant mortality and undoing racism. A health disparities brief addressing disparities in infant mortality and birth outcomes in L.A. County and an Infant Mortality, Preterm Births and Low Birthweight Fact Sheet have been released.
The first ALC-sponsored health disparities training workshop in April 2010 was a success with over 100 providers in attendance.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH promotes interventions supported by a positive youth development framework.				X
2. LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance.		X		

3. CPSP provides at-risk women with comprehensive services including prenatal care, education, and psychosocial support.	X			
4. AFLP assists pregnant adolescents in accessing prenatal and other necessary healthcare early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes.		X		
5. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.		X		
6. MCAH and CMS collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes.				X
7. MCAH, CMQCC and RPPC provide technical assistance to hospitals seeking to reduce elective deliveries less than 39 weeks gestational age.	X	X		X
8. RPPC provides consultation to delivery hospitals and supports implementation of clinical quality improvement strategies to address evidence-based quality improvement projects and improve risk-appropriate care.				X
9. LAC ALC works on increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.				X
10.				

b. Current Activities
Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, continue their work on improving infant health and birth outcomes.

L.A. maintains the LAC ALC website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC ALC continues with its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health. In December 2011, the ALC held a successful Racial Justice Leadership Institute training on undoing racism for collaborative members' staff, with a total of 42 participants. MCAH and CMS continue to collaborate with MOD on its Prematurity Campaign, which aims to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. The Association of State and Territorial Officers (ASTHO) is partnering with MOD to further promote its Prematurity Campaign. The Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit has been developed as a collaborative project with CMQCC, MOD and MCAH. It is being used at the local level to facilitate improvements and transform maternity practice care. MCAH has licensed the toolkit to MOD, which is disseminating it nationally as part of its Prematurity Campaign.

c. Plan for the Coming Year
LHJs will continue to perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist women in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up.

CPSP providers offer comprehensive prenatal care, including obstetrics, nutrition, health education, and psychosocial support. Local AFLP programs use outreach, home visitation, and follow-up with pregnant women to educate clients and stakeholders on the importance of prenatal care. Regional AFLP representatives meet to discuss strategies for improving prenatal care utilization. BIH provides community outreach and health education, to increase community

awareness of the importance of prenatal care. The newly revised BIH intervention provides a 20-session group intervention (10 prenatal and 10 postpartum) with complementary case management that provides support to empower clients to make healthier choices for their babies. Case management ensures linkage to prenatal services.

FIMR is working on a Home Interview data collection tool for use by local FIMR programs. In addition to streamlining the data-gathering process, the use of this standardized tool will assist MCAH in multi-year analysis of FIMR data.

L.A. County continues with its ALC work. The ALC plans to hold more health disparities training workshops for healthcare providers as part of its mission to increase local capacity to address the impact of racism on birth outcomes and infant health.
MCAH and CMS continue to collaborate with MOD and ASTHO on the Prematurity Campaign.

CMQCC and RPPC continue to provide technical assistance to other hospitals and LHJs who wish to reduce elective deliveries for pregnancies less than 39 weeks gestation.

State Performance Measure 10: *The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home,*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					
Annual Indicator					84.0
Numerator					206827
Denominator					246301
Data Source					CMS Net
Is the Data Provisional or Final?					Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	90	90	90	90	90

Notes - 2011
This new performance measure is the percent of CCS clients with a designated primary care physician or subspecialist physician who provides a medical home.

The numerator is the number of CCS clients with a designated medical home, as indicated by the County CCS Office.
The denominator is the unduplicated number of CCS clients during state fiscal year 2010-11 who were entered into CMS Net, the CCS reporting system.

a. Last Year's Accomplishments
This is a new performance measure. In 2008, the current set of Performance measures for California Children's Services were developed, which included that counties should indicate whether each CCS client has an identified medical home.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Improve the data base to provide the most accurate results for this measure.				X
2. As staffing permit , work with Regional Office staff and local programs to authorize a PCP in conjunction with the Special Care Center or specialist.	X			

3. Request that counties count only primary care or specialist physicians in this Medical Home measure.				X
4. As staffing permits, work with Regional Office staff, local program staff and stakeholder groups to promote medical homes for children enrolled in CCS.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Obtain detailed reports from counties on number/percent of CCS children with 'medical home' by individual vs. Clinic, and primary care doctor vs. specialist
2. Meet with county CCS administrators to review Medical Home definition, discuss how to consistently apply Medical Home definition in the CMS performance measure reporting of medical home provider.
3. Implement the 1115 Demonstration Waiver Project of which The Medical Home is a core component. The project will be evaluating innovative health care delivery models for children with CCS conditions. As outlined the the 1115 RFP, the Medical Home is the foundation of each of the 4 models of an integrated and coordinated health care delivery system.

c. Plan for the Coming Year

1) Develop and issue policy letter to request that County CCS offices identify only physicians, not clinics, as designated Medical Homes.
2) As staffing permits, work with local program staff and stakeholder groups to promote medical homes for children enrolled in CCS
3) Continue implantation of 1115 and analysis of initial and interval data. The California Children's Services Waiver Evaluation Plan for the 1115 Pilots is in the final stages of development and includes several measures of Medical Home function including being family centered, satisfaction of patient, family and providers, and appropriate healthcare access.

E. Health Status Indicators

California utilizes various data sources to complete the indicator data for the various HSIs. These include the Birth Statistical Master file (HSI 1, 2 and 7), the Death Statistical Master file (HSI 3 and 8) the Patient Discharge Data from OSHPD (HSI 4), the STD Surveillance report (HSI 5), the Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance(HSI 6) and the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau (HSI 11 and 12).
A composite of data gathered from the (1) Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance, (2) the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau, (3) the Federal Data Reporting and Analysis Bureau of DSS, (4) MediCal Care statistics from DHCS, (5) the HF Program Monthly Enrollment Reports from MRMIB, (6) WIC data from the WIC, (7) Juvenile Arrests reported by the Criminal Justice Center of the Department of Justice, and (8) Number of Dropouts from California Public Schools from CDE are used to complete the indicators for HSI 9.

>Low Birth Weight (LBW) and Very Low Birth Weight (VLBW) Indicators

In 2010, the percent of live births weighing less than 2,500 grams remained at 6.8 percent.

Among the largest race/ethnic groups, African Americans (12.2 percent) and Asians (7.9 percent) had the highest percent of LBW births. In 2010, Hispanics and Whites had the lowest LBW births at 6.2 percent and 6.1 percent, respectively. The percent of live singleton births which were LBW in 2010 was 5.3, a slight increase from 5.2 in 2008. For 2010, it was highest among African American infants at 9.9 percent compared to infants who were Asian (6.3 percent), Hispanic (5.1 percent) or White (4.1 percent).

Births less than 1500 grams are classified as VLBW. In 2010, the percent of live births which were VLBW was 1.1 percent, remaining relatively stable since 2000. In 2010, 2.6 percent of African American live births were VLBW. All other racial and ethnic groups were generally between 1.0 and 1.3 percent VLBW in 2010. In 2010, the percent of live singleton births that were VLBW was 0.9 percent, remaining constant since 2000. Among racial and ethnic groups, African Americans were twice as likely to give birth to singleton VLBW infants. In 2010, 2.0 percent of African American live singleton births were VLBW. Comparatively, 0.9 percent of Hispanic singleton births were VLBW, while Asians had 0.8 percent and Whites had 0.7 percent.

VLBW is almost exclusively related to prematurity with gestational age of less than 32 weeks. While not all causes of severe prematurity are well understood, women who have had previous preterm births, are carrying multi-fetal pregnancies, are African American, or are at the extremes of maternal age, have a well-documented risk of preterm delivery. Pre-existing medical conditions and lifestyle issues affecting women's health play a significant role in increasing risk.

VLBW infants are at significantly increased risk of infant mortality--nearly 105 times greater than infants born at normal birth weight. Morbidities associated with VLBW include Respiratory Distress Syndrome, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis and retinopathy of prematurity. Optimizing the outcome of VLBW infants requires improvement of risk-appropriate maternal-fetal care.

California seeks to improve its infant mortality rate. Amenable to policy interventions that contribute to infant mortality are disorders related to low birth weight. To evaluate variation, understand related issues and provide information on infant morbidity and mortality rates, MCAH funds several data projects. Perinatal Profiles of California, based at the School of Public Health, University of California, Berkeley, is a risk-adjusted mortality database that reports on sentinel events such as the proportion of VLBW infants born outside of tertiary care facilities. RPPC leaders review this data with hospitals during site visits. IPODR is a web-based database allowing evaluation of perinatal outcomes at the county and zip code levels. Data are used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress toward goals to improve the health of mothers and infants.

BIH addresses disparities in birth outcomes. The program provides African American women, their families and communities with support services addressing factors that negatively impact birth outcomes. Strategies to prevent prematurity and reduce LBW/ VLBW include culturally competent approaches to increasing timely and adequate use of prenatal care, educating women to modify behaviors that may promote preterm labor, and educating women on recognition of the signs of preterm labor.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of Maternal Child Health Programs, CityMatCH and National Healthy Start Association which provided tools to address infant mortality disparities. L.A. County created an Action Learning Collaborative (LAC ALC) website to provide information on resources/best practices on infant mortality and undoing racism. The ALC continues its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.

MCAH engages in numerous efforts to understand the risks and optimize outcomes for LBW/VLBW infants. Several MCAH programs target specific populations at risk for adverse

pregnancy outcomes. BIH serves pregnant and parenting African American women through a group intervention and complementary case management to improve the health and social conditions for these women and their families. The group intervention empowers African American women by providing information and skills in a culturally relevant and affirming manner. Research has shown that promoting capacity for social support influences birth outcomes by buffering the adverse effects of chronic stress. BIH is located in 15 LHJs where over 75% of California's African American live births occur. Direct services for at-risk populations are also provided through AFLP CDAPP and CPSP, which promote not only perinatal health but women's health, thus influencing infant outcomes of subsequent births.

MCAH implements quality improvement (QI) strategies to ensure a high level of care for neonatal and maternity care practices through CPQCC and CMQCC. QI toolkits on varied clinical topics are available on these collaboratives' websites and have been used by institutions across the state and the nation. RPPCs promote access to risk-appropriate perinatal care for pregnant women and their infants through regional QI activities, including assisting hospitals with data collection protocols, developing quality assurance policies and procedures, and providing resource directories, referral services, hospital linkages and technical assistance. BBC utilizes QI methods to implement evidence-based policies and practices that support breastfeeding within the maternity care setting.

Healthy eating, physical activity, and breastfeeding promotion are integrated within MCAH to promote healthy lifestyles and improve birth outcomes. PHHI promotes preconception health messages to women of reproductive age, integrates preconception care into public health practice, monitors indicators, and evaluates preconception health programs and interventions to guide policy strategies. LHJs conduct educational programs for women of reproductive age and providers, addressing health behaviors causing poor pregnancy outcomes. Resources and best practices for professionals and information for the general public are available through the initiative's website.

Examining data from mortality case reviews, birth defects surveillance, and the Maternal Infant Health Assessment survey guides MCAH in program planning and priority goal setting. Data are used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress toward goals to improve the health of mothers and infants. Data sources such as the CA Women's Health Survey are used to examine the evidence for public health practice.
Optimizing collaboration with strategic partners, using data to understand and inform efforts, and implementing public health strategies to eliminate disparities and promote health equity are essential in MCAH's continuing efforts to address LBW/ VLBW outcomes.
>Injury Indicators

Unintentional injury is the leading cause of death in children under aged 1 through 14. In 2010, the death rate due to unintentional injuries among children aged 0-14 was 3.3 per 100,000, way below the HP 2020 target of 36 per 100,000 for the general population. The death rate from fatal accidental/unintentional injuries to children aged 0-14 declined since 2007 when the rate was 5.3 per 100,000. In 2010, the rate was highest among African Americans (5.1), followed by Whites (3.5), Hispanics (3.2), and Asians (2.1). Rates among multiple race groups, Pacific Islanders and AIs were not calculated because of small cell sizes.

Among fatal injuries, those due to motor vehicle collisions are most frequent. The death rate from unintentional injuries due to motor vehicle accidents dropped from 1.8 per 100,000 children aged 0-14 years in 2009 to 1.0 per 100,000 in 2010. The rate for Hispanics (1.2 per 100,000) was slightly higher than the rate among Whites (0.9 per 100,000). The rate among other race/ethnicities could not be calculated due to small cell sizes. As the 2007 and 2008 rate reflects a change in methodology used to calculate this indicator, data in the table cannot be directly compared to rates reported in prior years.

The death rate from unintentional injuries due to motor vehicle traffic collisions fell from 11.5 per 100,000 children ages 15 through 24 years in 2009 to 9.0 per 100,000 in 2010. The recent decrease is a positive sign overall, as the Healthy People (HP) 2020 objective was 12.4 deaths per 100,000 for the general population. Injury is the leading cause of death among adolescents and among young adults aged 15-24 years. In 2010, the death rate from unintentional injuries due to motor vehicle traffic collisions was highest among Blacks (11.1 per 100,000 youth ages 15 through 24), followed by Hispanics (10.4), Whites (8.5), and multiple races (7.9). The rate was lowest among Asians (3.6). The rate among AIs and Pacific Islanders was not calculated due to small sizes.

The nonfatal injury rate for 2010 is highest for African American children aged 0-14, at 266.8 per 100,000 followed by White children at 203.1 per 100,000. Rates are lower among Hispanic (176.9 per 100,000), Asian/Pacific Islander (96.6 per 100,000) and AI (111.9 per 100,000) children aged 0-14 years of age.

The rate for nonfatal injuries due to motor vehicle crashes is below the HP 2020 target of 694.4 per 100,000 for the general population. The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger continues to decline, from 18.6 in 2009 to 16.8 in 2010. In 2010, the rate was highest among Blacks (28.1 per 100,000 population), followed by Hispanics (18.2), Whites (14.9), and Asian/PI (5.6). The rate was not calculated among AIs due to small cell sizes.

The hospitalization rate for all nonfatal injuries among children aged 0-14 years has decreased since 2000, when it was 284.9 per 100,000. By 2003 it had dropped to 257.3 per 100,000, and the trend has continued falling to 186.8 per 100,000 in 2010. This is below the HP 2020 target of 555.8 per 100,000 for the general population.

Motor vehicle traffic crashes are the leading cause of hospitalized nonfatal injuries among youth aged 15-24 in California. While hospitalization rates in this population increased from 147.7 per 100,000 in 2000 to 164.5 per 100,000 in 2004; this rate has decreased markedly since then. In 2007, there were 110.8 per 100,000 nonfatal injuries due to motor vehicle traffic crashes in youth aged 15 through 24 years. In 2010, the rate continued to decrease to 88.9 per 100,000 (numerators are based on principal diagnoses codes in hospital discharge data). In 2010, the rate was highest among Blacks (113.4), followed by Whites (103.2), AIs (83.2), and Hispanics (82.6). The rate was lowest among Asian/Pacific Islanders (38.7 per 100,000).

This injury-related HSIs enable California to identify trends, focus its prevention efforts and determine the success of these efforts. SAC has statewide data systems that track injuries, and makes grants to LHJs using funds from the Kids Plates program to increase the capacity of local organizations statewide to prevent injuries (e.g., traumatic brain injury, drowning, and burns). MCAH funds the Childhood Injury Prevention Program within San Diego State University's Center for Injury Prevention Policy and Practice (CIPPP) to provide technical support to LHJs' injury prevention activities. This support involves priority-setting, program selection, and evaluation. The Vehicle Occupant Safety Program coordinates CPS efforts across California by creating essential CPS partnerships that link state and local policy, enforcement, and educational efforts. California has a mandatory seat belt requirement and child safety and booster seat laws which are being promoted by a "click it or ticket" campaign. California's booster seat law was expanded to cover children to age 8. CIPPP revised and posted updated Safety Sheets on their website to reflect the changes and are available in English, Spanish, and Vietnamese. CIPPP distributed an updated notice concerning the new CPS law and distributed it to LHJs and to the Calif. Dept. of Ed., for redistribution to elementary schools and the California PTA.

The greatest risk to toddlers in California is drowning in back yard pools. MCAH provides funding CIPPP which works with LHJs and local building inspectors to improve code compliance with the "multiple barriers of protection" concept for existing homes and with fence law for new construction. CIPPP Safety Sheets are available to LHJs and widely promoted to private

pediatricians through the AAP-CA. Safety Sheets are also widely used by local social welfare agencies.

>Chlamydia (CT) Indicators

Chlamydia trachomatis (CT) infection is the most common reportable communicable disease in California. In 2010, over 74,000 cases were reported in females aged 15-24 years, accounting for 70% of female CT cases. The CT rate per 1,000 women aged 15 through 19 years was 22.5 in 2010 reflecting ongoing increases. Female African Americans aged 15-19 continue to have the highest CT rate at 69.7 per 1000 in 2010 compared with Latinas (14.2 per 1000), Whites (8.1 per 1000), and Asian/Pacific Islanders (5.8 per 1000).

For 15-24 year old females, CT prevalence has been fairly stable since 2000 and differed by health care setting. In 2010, CT positivity in females aged 15 to 24 years in family planning sites was 4.9 percent compared with 4.7 percent in managed care settings and 16.8 percent in STD clinics. All estimates exceed the HP 2010 objective of 3 percent for females age 15-24 in STD and family planning clinics. The HP 2020 target is 6.7% among 15-24 year old females attending family planning clinics.

In 2009, 9.9 per 1,000 women aged 20 through 44 years had a reported case of CT.; with more than 70,000 cases reported in 2010, the CT rates increased to 10.6 per 1000 . The combined 20-44 years age group is not particularly useful for monitoring populations at risk for CT, as case rates in women 20-24 and 25-29 are significantly higher than rates among women age 30 and older. In 2010, CT rates were highest for the 20-24 age group at 29.5 per 1000. While the chlamydia rate among women aged 20-44 is considerably lower that for women aged 15-19, this figure had similarly been rising over the past five years.

The increases seen in case-based CT rates may be due to screening practices, including targeted screening of older women and the use of more sensitive screening tests . Use of age-specific case-based rates alone may not be adequate for evaluating impact of CT control interventions in statewide or local settings/populations. Other health status measures to consider include: CT positivity rates, the percent having been tested for CT in the past year, repeat testing rates (to reduce repeat infections), and population-based or clinic-based behavioral surveillance to assess awareness and access to CT testing.

As California has high screening levels for young women compared to national estimates, data from sentinel prevalence monitoring in specific health care settings are important for comparison with case-based rates. Nationally, young men and women aged 15 to 24 years have 4 times the reported rates for gonorrhea and chlamydia compared with the total population, according to the CDC
[http://www.cdc.gov/std/health-disparities/age.htm].

The STD Control Branch multifaceted strategy to reduce CT prevalence includes working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership. In addition, STD Control Branch has released guidelines for expedited partner therapy and field therapy for CT to address infections among partners. The STD Control Branch multifaceted strategy to reduce CT prevalence includes working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership.

Surveillance efforts aim to enhance timeliness and completeness of CT case data and prevalence monitoring test result data through electronic transmission. Leadership and partner development efforts include initiatives such as 1) working with outside partners to address inequities in CT rates associated with race/ethnicity, and 2) partnering with medical groups to provide CT screening rates to individual providers.

Policywise, AB 499 which will allow a minor who is 12 years of age or older to consent to medical care related to the prevention of a sexually transmitted disease became law (Chapter 652,

Statutes of 2011)

>Infant and Child Population Demographic Indicators

In 2010, the projected child population was 14,169,093.//2013// By race, 11,287,125(80%) were White; 1,430,075(10.1%) were Asian; 856,368(6.0%) were African American; 467,026(3.3%) were multi-racial; 74,518(0.5%) were AI/AN, and 53,981(0.4%) were Native Hawaiian or Other Pacific Islander (NH/PI). Of the 2008 population aged 0-24 years, a total of 6,504,093 (47%) were of Hispanic ethnicity. The projected 2010 Hispanic population aged 0-24 years was 6,749,658. Across the U.S., California has the largest population of Hispanic residents and the largest percentage of Hispanics of Mexican origin.

Non-Hispanic white children, ages 0- 18 are now less than half of all children with 73% comprising minority populations with the growth driven by an increase in Hispanic children. The Hispanic child population in California increased by over 700,000 between 2000 and 2010 census, at the same time that the non-Hispanic white child population fell by almost the same amount over the same period [48]

Comparing the 2000 and 2010 census data , California had the largest increase in the numbers of non-Hispanic Asians compared to all other states and the third largest number increase of non-Hispanic, Two or more races in their child population. California also had the biggest decrease in the number of non-Hispanic AI/AN and non-Hispanic white children ages 0-18 among all states. [A]

Trends in the population of children and young adults help project potential needs for health care and public health services. The increasing racial and ethnic diversity poses challenges to health care delivery and the public health system. More than ever, MCAH is continually addressing cultural competence and cultural differences in to ensure access to services and address disparities.
Having an understanding of California's ethnic population characteristics and trends is important for understanding the conditions and policy challenges facing California's health care delivery and public health systems. Cultural factors such as behavior and lifestyle influence health outcomes. More than ever, MCAH is continually addressing cultural competence and cultural differences in to ensure access to services and address disparities.
>Indicators related to Child Enrollment in Various State Programs

The 2010 population of California age 0-19 was 11,253,589. By race, 80% were White; 10% Asian; 5.8% African American; 3.5% Multiracial; 0.5% AI/AN; and 0.4% NH/PI.

Among children ages 0-19, 28.7% lived in a household headed by a single parent in 2011, a slight increase from 26.8 in 2010. The proportion living in households headed by a single parent has been consistently highest for African American children (59.4% in 2011); figures are also high for AI/AN (45.6%) and Multiracial (32.5%) children.

In 2011, 10% of children 0-19 years of age received Temporary Assistance for Needy Families (TANF) or CalWorks. By race, 28.9% of African American, and 16.1% of NHPI children received TANF, compared to 9.5% of White, 15.9% of AI/AN; 4% of Asian, and 5.9% of multiracial children. While 12% of the U.S. population resides in California, it serves 33% of the nation's TANF overall recipients. Effective July 2011, TANF months of assistance limit was reduced from 60 to 40 months; eligibility was reduced by counting more work income for qualifying purposes; and, child care and employment services were cut. Monthly cash grants were reduced by 8% dropping the monthly maximum to $638 for a family of three, lower than the $663 that California offered the same family in 1988. There is a plan to split CalWorks into three new programs; the first would function similar to the traditional program but would only have access for two years, a second would provide two more years of services but only if the parent meets federal requirements which means 30 hours a week in a job not financed by public subsidies and a third

program for "safety net" cases, i.e., families without a qualified working parent into a new Child Maintenance program where paperwork requirements are loosened and require an annual child health exam. The third program is for those who cannot work, unwilling, sanctioned or undocumented and receive a lower grant.

The number of children enrolled in Medi-Cal (Medicaid) in 2008 was 3,497,465. This was up 106,000 from the previous year.

Enrollment in HF continue to shrink. In 2008, 895,440 children were enrolled in HF; by 2011, 870,784 were enrolled. The 2011 enrollment includes 495,393 White children (56.9%; including Hispanic), 81,577 (9.4%) Asian; 15,681 (1.8%) African American; and 927 (0.1%) AI/AN. Race was Other/ Unknown for 274,781 (31.6%) children enrolled in HF in 2011.

The foster care caseload was 59,248 at the end of 2010. This figure has been steadily decreasing. In contrast, there were 89,913 foster care cases in 2003.

In 2010, 2,115,610 children were enrolled in the Food Stamp Program, including: 1,705,057 (80.6%) White; 42,240 (2.0%) Multiracial; 220,344 (10.4%) African American; 136,775 (6.5%) Asian; 7144 (0.3%) AI/AN; and 4051 (0.2%) Other/Unknown children. As part of a push to boost enrollment closer to the 75 percent participation average for states, Gov. Jerry Brown signed legislation eliminating some barriers to access. One hurdle, a fingerprinting requirement for those 18 and older, ended. Another barrier, a requirement that CalFresh recipients file quarterly reports, will end next year. Instead, California will switch to simplified semi-annual reporting, beginning in 2013.

Of those aged 0-19 years, 2,063,125 were enrolled in WIC in 2011. This includes 577,993 (28%) White (including Hispanic); 134, 340 (6.5%) African American; 90,181 (4.4%) Asian; 42,240 (2.%) Multiracial; 7,144 (0.3%) AI/AN; 12,232 (0.6%) NHPI; and 303,976 (14.7%) Other/Unknown.

There were 2634 arrests per 100,000 for juvenile felony and misdemeanor offenses among those under 19 years in 2010. This rate continue to decrease annually since 2007.. Arrest rates continue to be highest for African American (7352 per 100,000 children) and NHPI (3148 per 100,000) juveniles. The 2011-12 state budget established a framework to shift primary responsibility for a number of public safety and related services including the juvenile justice crime prevention programs and child welfare services from the state to the local counties effective October 2011.

The cohort dropout rate for the class of 2010 was 17.5 percent. For the first time, these data are based on four years of longitudinal student data used to calculate a cohort rate. As such, these data serve as a baseline and should not be compared to rates from previous years. By race, 29.2 percent of African-American, 22.8 percent of AI/AN, 20.4 percent of NHPI, 11.1 percent of White, and 7.7 percent of Asian students dropped out.

The 2009 passage of Senate Bill 651 mandated a reform in how high school dropout rates are to be reported. With the newfound awareness of dropouts, it puts into perspective the realization that California is now spending more on prisons than on the University of California and the California State Universities combined, with 85% of those inmates dropouts [49]

Overall increasing trend were observed in the number of children ages 0 to 19, the percent of households headed by a single parent, WIC enrollment and the percent of the population enrolled in CalWorks (TANF). A decreasing trend in HF, CalWorks and Cal-Fresh enrollment; those living in foster home care and the rate of juvenile arrests were observed. Enrollment trends in various juvenile justice, health and social service programs help in planning for future service needs. California's MCAH does not fund these programs although Title V funding is used to support the maternal and child health needs of populations that utilize these programs.

>Population by Geographic Living Area

In 2010, an estimated 255, 300 children resided in rural areas and 10,998,200 lived in an urban setting. Over the years, the proportion of California's child population living in rural areas has slowly decreased and conversely, slowly increased in urban areas. In 1980, 2.4% of the population lived in rural areas and by 2010, decreased to 2.27%.

Public health needs of rural and urban populations vary. Rural-urban health disparities exist with respect to shortages of some types of PCPs (obstetricians and pediatricians), shortages of specialized mental health providers and oral health providers, prevalence of tobacco use and drinking-and-driving, and delays in screening and diagnosis of cancer. In addition, particular geographic, demographic, and cultural conditions in rural areas present obstacles to both rural residents seeking services and providers who would deliver them. [50]

Disparities in chronic disease prevalence and related health behaviors, issues of diversity and shifting population demographics, and access and coverage for the underinsured & uninsured all become more complicated in rural areas. MCAH LHJs in rural areas, in addressing these issues, face challenges regarding workforce recruitment, retention and training, epidemiologic investigation, information technology, and telecommunications. Many social determinants of health unique to rural areas impact health status. Some examples include lower wages, disproportionately high housing costs (relative to wages), psychological impacts associated with increased isolation, fewer jobs, high numbers of underinsured or uninsured, increased risk of poverty, and lack of educational opportunities. Rural communities have a dearth of healthy food outlets and access to transportation due to low population density thus limiting access to healthy food and health care sites. Other barriers in the rural community to being physically active include lack of sidewalks, street lights an exercise facilities. Taken together, these factors contribute to increased inequities in the health status of rural residents.

Similarly, the built environment in urban areas creates opportunities and challenges. Higher concentrations of people make it easier to offer basic infrastructure and public health services. However, urbanization tends to create health hazards making it more environmentally as well as socially unsustainable. Health hazards resulting from urbanization are mainly connected to air pollution, as well as crime, traffic and lifestyle. A health hazard common in, but not exclusive to, the cities in California is connected to lifestyle and consumption patterns, including dietary changes and obesity.

There is interest and recognition within MCAH to address health inequities in the rural and urban population. To address health disparities, MCAH will take into account differences in rural and urban settings, with strategies that focus on environmental changes involving all sectors, through local programs, and policies to create social norm changes.

>Poverty Indicators

The percent of the Californians at various levels of the FPL has been steadily increasing. Those below 50% FPL increased from 5.5 in 2007 to 7.5% in 2010; those between 50% and 100% FPL increased from 12.2 in 2007 to 16.3% in 2010; and, those between 100% and 200% FPL increased from 34.3 in 2007 to 36.7% in 2010.

The latest data show that the recession had a profound impact on California, particularly families with children. There has been a significant increase in poverty among children across all FPLs. The percent of children below 50% FPL increased from 7.1 in 2007 to 10.6 % in 2010; those between 50% and 100% FPL increased from 7.8 in 2007 to 23.5% in 2010; and, those between 100% and 200% FPL increased from 41.3% in 2007 to 47% in 2010.

Statewide, 11 percent of kids grow up in communities where 30 percent or more of the residents live in poverty which mirrors the national average, but not all counties experience the impact equally. Among California's counties, Marin has the smallest number of kids living in

communities where at least 30 percent of residents are poor, at 1 percent. In contrast, Fresno has the highest proportion at more than 38 percent. And among the largest U.S. cities, Fresno ranks fifth with kids raised in communities surrounded by impoverished conditions.[51] Children in poverty frequently live in stressful environments, without the necessities most children have, including adequate nutrition to enable physical and cognitive development. Children from low-income families are more likely to go hungry; reside in overcrowded or unstable housing; live in unsafe neighborhoods; and receive a poorer education. They also tend to have less access to health care, child care, and other community resources, such as quality after-school programs, sports, and extracurricular opportunities.
From a life course perspective, poverty is a barrier to opportunity, with poor children more likely to have diminished access to health care translating to poorer health outcomes or do poorly in school translating into lower lifetime earnings. Although family violence, youth substance abuse, and juvenile crime are found across the socioeconomic spectrum, child poverty is correlated with these risk factors as well.
There are numerous possible approaches to improving the health of poor populations. The most essential task that CDPH is striving for is to ensure the satisfaction of basic human needs such as clean air, safe drinking water, and adequate nutrition. Other approaches adopted by the CDPH programs include reducing barriers to the adoption of healthier modes of living and improving access to appropriate and effective health and social services.
A growing body of research confirms the existence of a powerful connection between socioeconomic status and health. MCAH understands poverty and its effects on health and together with its stakeholders, endeavors to influence local and state policymakers to reduce the burden.

In November 2011, the U.S. Census Bureau released information about a revised method for calculating poverty.[52] . The revised method account for the varying cost of living threshold in various geographic areas. The supplemental poverty measure, which uses the revised methodology will be used for research purposes to provide an alternative lens to understand poverty and measure the effects of anti-poverty policies. However, the traditional poverty measure will continue to be used for budgeting purposes, since increasing the number counted as poor with the revised methodology increases the number that may qualify for public assistance programs.

F. Other Program Activities

>MCAH Hotline, MCAH Web Hits and the National Text4baby

Both the State and LHJs have telephone hotlines that provide information regarding maternal, child and adolescent health services and programs. There are several statewide toll free telephone hotlines run by the State of California, including one for MCAH: 1-866-241-0395. The combined number of telephone calls to the local MCAH toll-free lines was 49,748 in FY 2008-09, up from 42,239 in FY 2007-08.

The MCAH web site received 57,323 hits in 2008/09 /2012/and 29,716 hits in 2009/10. Calls to the local MCAH toll-free lines decreased to 24,357 in FY 2009-10, partly due to increased use of local web pages. //2012// Local MCAH web sites have also been accessed by community members. For example, Contra Costa County reported receiving 84,074 hits to their MCAH web site.

Text4baby is a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition, Text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Of the 42,518 who enrolled in text4baby nationwide as of May 2010, 9.5% (n= 4024) of women were from California.

>Emergency Preparedness

CDPH launched a program to help Californians find local H1N1 and seasonal influenza immunization information using cell phone texting inquiries, Facebook applications, Twitter and Web widgets. CDPH is promoting the campaign through outdoor advertising, public service announcements and social media. CDPH also launched a new television campaign, entitled "Hands", that lays out the simple facts about H1N1 and encourages vaccination.

MCAH continues to be active in providing updated information about H1N1, perinatal transport and breastfeeding in emergency situations on their website and to LHJs. The information offered is appropriate for pregnant women, parents, clinicians and health officials. Several local MCAH programs participate in collaboratives and have developed activities regarding emergency preparedness for the MCAH population

>Home Visiting Programs

Ten counties in California utilize Nurse Family Partnership (the David Olds home visiting model) to follow high-risk, first-time pregnant women, their children and families. The Olds model is a home visitation model that utilizes public health nurses; other counties utilize a home visitation format with staff ranging from community health workers to registered nurses.

A few counties are applying for federal grants to run the Nurse Family Partnership. Also, a few local Public Health Departments are developing or currently implementing their own home visiting programs to provide assessment of mother and infants, health education, and information and referral for needed services./2012/ MCAH is the designated stat entity to apply for and administer HRSA and Administration of Children and Families (ACF) HVP. MCAH engaged stakeholders in selecting 20-30 communities to implement Nurse Family Partnership and HF America HVPs, based on the Federal FY 2010 budget.

>American Indian/ Native Alaskan Health

MCAH provides $424,000 to the Indian Health Program of the Primary and Rural Health Division of DHCS for improvement of AI/AN MCH outcomes and support the American Indian Infant Health Initiative, which offers home visitation in 5 counties with the greatest AI/AN MCH disparities. Services include case management and lay (Community Health Representative) home visitation that includes health assessment, education, referral and transport. Bi-annual workshops provide professional development for staff and for case review across sites. Collaboration with WIC and Child Protective Services is fostered to improve family outcomes.

Additional resources are available to AI/AN families throughout California. For example, the California Courts recently developed the Statewide Directory of Services for Native American Families. //2012//

>Human Stem Cell Research (HSCR) and Women's Reproductive Health

MCAH created the HSCR Program in 2005 to fulfill legislative mandates through the development of statewide research guidelines, protections for women donating oocytes for research, requirements for HSCR review and approval, and HSCR reporting requirements.

MCAH convened the HSCR Advisory Committee in 2006. In 2007, CDPH approved the statewide guidelines for HSCR submitted by the Advisory Committee. These guidelines were revised in 2008 and 2009 to reflect advancements in the HSCR field. ***/2013/ The guidelines were revised in 2011 to maintain consistency with changes in the HSCR field and state regulations. //2013//***

The HSCR Program developed reporting forms for research involving human embryonic stem

cells and oocyte retrieval in spring 2008. In the first year of data collection, 15 review committees reported on 244 HSCR projects. In the second year of reporting, 18 review committees reported on 303 HSCR projects. /2012/ The third year included reports on 350 HSCR projects. HSCR will submit its second biennial review to the Legislature in Spring 2011. //2012// ***/2013/ In 2011, 17 review committees reported on 364 HSCR projects. No projects involved women donating oocytes. //2013//***

>Prenatal Screening Services, Umbilical Cord Blood Banking, and Pregnancy Blood Banking

/2013/Prenatal screening services are discussed in Performance Measure 01. In 2011, GDSP fully integrated all components of first trimester screening (nuchal translucency ultrasound plus first and second trimester blood screens).//2013// The California Birth Defects Monitoring Program (CBDMP) was established in 1982 to conduct research and surveillance of birth defects and maintain a birth defect registry. ***/2013/In June 2010, the California legislature approved the use of federal funds for umbilical cord blood banking, and the cord blood program was transferred to the University of California Los Angeles (UCLA).//2013//*** CBDMP collaborates with GDSP to maintain the Pregnancy Blood Bank, which stores blood samples from GDSP's Prenatal Screening Program. ***/2013/The bank currently stores more than one million samples from California women.//2013//***

>Oral Health Promotion

MCAH recognizes the importance of oral health as being integral to overall health and is responding with a variety of strategies to increase this awareness among its targeted populations. MCAH is contracting with UCSF for a dental hygienist to serve as the MCAH Oral Health Policy Consultant to provide technical assistance at both the state and local levels. Guidelines within MCAH programs have been revised to include oral health recommendations for pregnant and postpartum women and their young children. MCAH collaborates with organizations concerned with promoting oral health throughout the state, including formulating recommendations for the newly completed statewide perinatal oral health guidelines.

State budget cuts to the Children's Dental Disease Prevention Program and Medi-Cal adult dental services will be very challenging to MCAH LHJs which provide education and referrals to their clients. MCAH has 18 ***/2013/19//2013//*** LHJs that have selected oral health as a priority objective. Eleven /2012/ Ten //2012// ***/2013/11//2013//***of these programs have a minimum of one part-time oral health coordinator/consultant on staff. Another 25 /2012/ 21 //2012// /2013/29/2013// of these programs have a minimum of one part-time oral health coordinator/consultant on staff. Another 25 LHJs collaborate on community dental health advisory boards. The boards develop and implement local dental screening and prevention programs and work to increase access by encouraging more dentists to become Denti-Cal providers.

G. Technical Assistance

MCAH requests training and resource materials in the area of capacity assessment, including: 1) Clinical capacity assessment (availability of and access to clinics, maternity beds, neonatal intensive care units, etc.); 2) Clinical workforce assessment at state and county levels (physicians, obstetrician/gynecologists, pediatricians, dentists, nurses, etc.); 3) Public health capacity assessment (epidemiologists, program evaluators, etc.); 4) Integration of needs assessment, capacity assessment, and implementation planning, and; 5) MCAH public health workforce assessment.

MCAH requests guidance in conducting the Home Visitation Program Needs Assessment as mandated by the Maternal, Infant, and Early Childhood Home Visiting Program in the Patient Protection and ACA. Specifically, MCAH requests assistance in identifying the criteria by which

MCAH can measure the effectiveness of evidence-based early childhood home visiting models that qualify under the new legislation, guidelines for reporting to fulfill the needs assessment requirements and developing quantifiable measures for setting benchmarks.

MCAH requests training and resource materials in the area of capacity assessment, specifically on : 1) developing process indicators related to direct healthcare services; (2) community level capacity assessment; (3) linking needs analysis with capacity assessment to identify priorities and resource allocation and (4) "train the trainer" on conducting state and community-level capacity assessment 5) internal organizational capacity assessment 6) scope and breadth in assessing systems capacity beyond MCAH services.

MCAH requests assistance in reviving an annual (or biennial) MCAH California Conference. The conferences would be a collaborative effort undertaken by the MCAH, MCAH Action (the statewide organization of local MCAH Directors), and the UCB School of Public Health. Such conferences were held annually in California prior to discontinuation in 2002 due to budget constraints. The conferences were well attended, with approximately 700 participants each. Conference locations alternated between northern and southern California. The conference provided opportunities for participants --from the state, local jurisdictions, academia, and other interested groups --to network and strategize on issues affecting the health of women, children and families in California. Each year the conference had a theme. MCAH encouraged interested parties to submit general or scientific abstracts on current and emerging MCAH issues pertinent to the theme. Programs that addressed the conference theme were recognized.

MCAH has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of MCAH and program evaluation. CMS would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of state travel.

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in MCAH would be valuable to both the MCAH and CMS. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCAH programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost effectiveness and fiscal neutrality of programs run by the MCAH and CMS.

Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff's ability to provide this critical information to program managers and administration officials.

Hands-on training on smoothing techniques to deal with geographic areas (e.g., census tracts) for which there are too few observations to generate statistically stable counts or rates; recommended statistical tests for use with geospatial data, including for smoothed data.

The CDC reports that more than 40 percent of women experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal

death. MCAH is working to monitor maternal morbidity. MCAH is developing a MQI project and has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

MCAH requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process.

/2012/MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity and mortality that will serve as a framework for improved maternal standard of care. Assistance is needed on study design, case selection, medical record review protocols, guidance on whether cases are pregnancy-related or pregnancy-associated, and development of recommendations to reduce morbidity and mortality based on findings.

MCAH requests assistance to translate current evidence regarding contributing factors to racial disparities into Title V programmatic activities and build capacity in addressing the impact of the social determinants of health . Disparities in infant and maternal health outcomes persist and are widening in regards to maternal mortality so MCAH needs to expand current strategies. MCAH is also invested in moving to primary prevention and applying the life course theory to interventions but moving from a programmatic approach to reaching out to influence decision making in other disciplines is a new and emerging role.

It is essential to communicate the value and make the case for the importance of MCAH programs in contributing to health across the life course. MCAH requests assistance in developing a set of standardized messages that state and local MCAH programs could use.//2012//

/2013/ MCAH requests assistance in the area of capacity development related to methodological training for new and junior staff on epidemiological methods and conducting cost-effectiveness analysis, assistance on obtaining youth input, translational research, addressing social determinants of health, methodology development for longitudinal analysis of preconception and interconception health and standardized messaging.

CCS requests assistance from MCHB in adapting the National CSHCN survey to California's CCS population in order to move forward with State Performance Measure 3, The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. The national survey results offer some insight into satisfaction, insurance, access of families of CSHCN in California, but does not differentiate between CCS eligible and other CSHCN so that results are not directly applicable to the CCS program. Its length is also limiting. Use of an adapted survey will allow assessment, specific to families and children in the CCS program, of several priority objectives of the Title V needs assessment, including implementation of medical homes, increasing family partnership in decision making, and satisfaction with services;. In addition, an adapted survey would allow the CCS program to monitor family satisfaction as changes are made to the CCS over the next 5 years. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	43315317	44632445	42300762		41389219	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	1290479684	1292129195	1366907980		1306322819	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1236656992	1399992782	1353823835		1272272105	
7. Subtotal	2570451993	2736754422	2763032577		2619984143	
8. Other Federal Funds *(Line10, Form 2)*	2221953	2201633	14775679		30690686	
9. Total *(Line11, Form 2)*	2572673946	2738956055	2777808256		2650674829	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	28042839	25490798	28504437		28008354	
b. Infants < 1 year old	35440694	40756466	34687361		41436955	
c. Children 1 to 22 years old	120612014	122301136	117382670		132469454	
d. Children with Special Healthcare Needs	2383717501	2545164487	2580029837		2415869622	
e. Others	0	0	0		0	
f. Administration	2638945	3041535	2428272		2199758	
g. SUBTOTAL	2570451993	2736754422	2763032577		2619984143	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		100000		100000	
c. CISS	132000		140000		150000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	175000		175000		148800	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
Home Visiting - Expa	0		0		9430000	
Home Visiting - Form	0		0		11510679	
Pregnant & Parenting	0		2000000		2000000	
PREP	0		0		6501207	
Project LAUNCH	0		0		850000	
Home Visiting Prog.	0		11510679		0	
Project LAUNCH	0		850000		0	
Others	1821240		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2247648806	2395005281	2441246289		2267878641	
II. Enabling Services	260227739	239908163	254669900		255442699	
III. Population-Based Services	36067685	66184574	36188755		65174957	
IV. Infrastructure Building Services	26507763	35656404	30927633		31487846	
V. Federal-State Title V Block Grant Partnership Total	2570451993	2736754422	2763032577		2619984143	

A. Expenditures

The budget and expenditures for FFY 2011 are presented in Forms 2, 3, 4, and 5.

/2013/ The reductions in federal Title V funding has resulted in programmatic adjustments to reduce expenditures in infrastructure building services which will affect the following:

MCAH Division

MCAH is reducing 6.0 positions and over $6.8 million in funding expenditure authority for FY 2012/13. Reductions to travel and general expense allocations will limit MCAH's ability to conduct mandatory on-site program reviews, provide technical assistance and respond to information requests from LHJs and MCAH stakeholders. The positions being eliminated are:

> Nurse Consultant III (Specialist) -- Elimination of this position limits technical assistance capacity to support oversight and effective implementation of newly revised scope of work (SOW) for local MCAH, BIH, and AFLP programs. Nurse Consultant capacity for oversight, development, and long-delayed improvements to the Comprehensive Perinatal Services Program (CPSP) will be reduced by 25 percent. These functions are necessary to ensure CDPH/MCAH compliance with statutory requirements and Title 22 regulations. In addition, the loss of this position will reduce the capacity to develop and implement a health systems framework for coordination and integration of local MCAH, home visiting, and other community programs that make up the local MCAH public health system.

> Three Associate Governmental Program Analysts - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.

> Two Staff Service Analysts - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.

> Public Health Medical Officer III-- The elimination of this position limits the ability of MCAH to address the rising rate of maternal morbidity and mortality, a newly emerged

health issue in the last decade.

Primary and Rural Health Division (PRHD)

In FY 2012/13 the PRHD will be reduced by $373,000 and eliminate 4.0 state positions at DHCS. The PRHD provides training, technical assistance, and limited funding to primary care providers in underserved areas throughout the state to sustain and improve the primary care infrastructure. This assistance enables primary care clinics to plan and evaluate their systems of primary and preventive care delivery to meet the needs of high risk, underserved populations, including women and children. Targeted clinics include those located in rural areas and clinics that serve migrant farmworkers and American Indians. Additionally, the PRHD supports the implementation of the American Indian Infant Health Initiative (AIIHI). This program provides home visitation services to high-risk pregnant and parenting American Indian families. Services include assessment, counseling, referrals/follow up to medical and social services providers. The following are the positions that will be eliminated:

> Word Processing Technician -- Elimination of this position will impact contract oversight and delivery of annual reports. Primary care clinics will be additionally impacted due to delays in Tribal notification of Medi-Cal updates.

> Associate Governmental Program Analyst -- Elimination of this position will cause delays in grant execution, limited support to DHCS divisions for Tribal notices, and delays in providing technical assistance and support to Indian health clinics.

> Health Program Specialist I -- Elimination of this position will decrease support to community health centers, Federally Qualified Health Clinics, rural health clinics, and other rural health providers for funding applications.

> Nurse Consultant III (Specialist) -- Elimination of this position will delay providing clinical technical assistance, limits staff support to mandated Indian health advisory group, and delays development and updates of policy and procedures.

Audits and Investigations (A&I) Division
A & I performs audits on MCAH local contracts to ensure fiscal accountability and that federal requirements are met. A proposed reduction of $182,000 to A&I will result in a reduction in the number of audits to what has historically been performed.

> APN
Reductions and redirections of the Title V funds resulted in a 25% reduction in the APN for FY 2011/12 and complete elimination by July 2012.

> CDAPP
For FY 2011/12 funding for CDAPP was reduced by 50% to about $600,000 and the program will be eliminated starting July 2012. A resource and training center was contracted to provide resource materials, educational webinars and maintain the CDAPP website and listings of local CDAPP affiliates.//2013//

B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2011 is $43,315,317. Preventive

and primary services for pregnant women, mothers, and infants are designated to receive $12,800,106 (29.55 % of the total), preventive and primary services for children to receive $14,272,848 (32.95 %) and CSHCN to receive $13,603,489 (31.41%).

/2012/The proposed FFY 2012 allocation is $42,300,760 Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,160,420 (31.11 % of the total), preventive and primary services for children to receive $13,476,402 (31.86 %) and CSHCN to receive $13,235,668 (31.29%). //2012//

/2013/The FFY 2013 allocation is $41,389,219. Services for pregnant women, mothers, and infants are designated to receive $13,055,182 (31.54 %) services for children to receive $13,573,945 (32.80 %) and CSHCN to receive $12,560,334 (30.35%). The required match is $31,041,914, California's FFY 2013 budget for Title V MCH programs includes $1,306,322,819 in state funds.//2013//

> State Match/Overmatch
California expects to receive $43,315,317 in Federal Title V Block Grant funds for FFY 2011. The required match is $32,486,488. California's FFY 2011 expenditure plan for MCAH programs includes $1,290,479,684 in state funds. The dramatic increase in California's expenditure plan for FFY 2011 for the provision and coordination of services to the Title V MCAH population is due to the reporting of CSHCN data on actual expenditures. Previously the Electronic Data Systems (EDS) MR 922 report was used to provide the data for these numbers. However, a change to the EDS system for this report changed something in the data compilation and the numbers were not correct as they were grossly understating the expenditure data. Therefore, numbers from previous years' data submission to this year's data submission show a marked increase for the expenditures as the number is projected upon the actual expenditure data from FY 09/10 instead of the MR 922 report. Reporting of expenditure data has been updated and no longer uses the report it used in prior years. //2011//

/2012/ California expects to receive $42,300,760 in Title V funds for FFY 2012. The required match is $31.725,5701,California's FFY 2012 budget for Title V MCH programs includes $1,366,907,980 in state funds.//2012//

>Administrative Costs Limits
In FFY 2011 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2011, California will expend only 6.09 % of Title V funds on administrative costs.

/2012/ In FFY 2012 ***/2013/and 2013//2013//*** no more than 10 % of the Title V MCH Block Grant funds will be used for administrative costs and California will expend only 5.74% ***/2013/ and 5.31%, respectively,//2013//*** on administrative costs.//2012//

>Definition of Administrative Costs
In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH Division Operations Sections. Funds supporting State program and data staff (but not administrative staff) in MCAH and CMS are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of MCAH. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

>"30-30" Minimum Funding Requirement
At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-

based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community 187 based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

/2013/ Since FY 2008/09, LHJ quarterly time surveys were implemented to ensure that the "30-30" minimum funding requirement is met. //2013//

>Maintenance of State Effort
CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by MCAH and CMS.

The State's General Fund contribution for FFY 2011 is $1,290,479,684 which is $1,203,320,934 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989. /2012/The State's General Fund contribution for FFY 2012 is $1,366,907,980 which is $1,279,749,230 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989. //2012//

>Budget Impact
The combined effect of the state's budget deficit and loss of revenues due to the economic downturn resulted in a budget gap of $26.3 billion for Fiscal Year 2009-10. All California State General Funds (SGF) for MCAH were eliminated effective July 1, 2009, reducing the state and local MCAH Program budget by $20.3 million in SGF and $12 million in related matching Federal Title XIX funds.

The loss of SGF to MCAH Programs, BIH, AFLP, CPSP and CBDMP has resulted in deep cuts to local staffing, public health prevention activities, and the numbers of clients served. At the local level, the loss of SGF has reduced or eliminated the capacity of LHJs to provide public health nurse home visiting programs, as well as the LHJs' ability to provide outreach to the community by educating the MCAH population regarding such issues as SIDS, domestic violence, injury prevention, safety promotion measures and accident prevention, preconception care, early prenatal care, STDs and family planning, access to care, oral health, breastfeeding, childhood nutrition, childhood obesity, and guidance and support.

Statewide, the LHJs allocate approximately 3.25% of Public Health Realignment funds to local MCAH programs. In FY 2006-07, total Public Health Realignment funds transferred to counties equaled $1,538,651,128. In FY 2008-09, total Public Health Realignment funds transferred to counties equaled $1,372,049,262 and FY 2009-10 will be further reduced to approximately $1,310,000,000.

Given that the current fiscal year's public health realignment funding distributions are projected to

be approximately $62 million lower than FY 2008-09 distributions, the MCAH reductions in FY 2009-10 can be estimated to be approximately $2,015,000 in realignment funding and an additional $705,000 in matching Title XIX across local MCAH, BIH and AFLP programs.

>State MCAH Support
MCAH has lost the ability to leverage SGF to draw down Title XIX matching funds. The loss of $3.5 million resulted in an additional loss of approximately $1 million in federal Title XIX matching 188 funds. It reduced capacity at the local level to collect data has impacted the State's ability to document positive program outcomes and identify and address needed changes. State staffing levels were reduced -- vacant positions have not been filled, creating added work burden for remaining State staff. Resources were reduced to coordinate services across LHJs and advocate for vulnerable at-risk MCAH populations. There was an overall reduction in statewide meetings, which are essential to assuring statewide program equality, information sharing, training, and problem solving. There was travel reduction for state staff to audit and monitor budgets and operations and provide crucial technical assistance.

/2012/State General Fund monies have not been reinstated. Title V federal funds were reduced in FFY 2011, which has resulted in a reduction to local allocations for BIH and AFLP. //2012//

>CBDMP and CPSP
Of the $3.5 million SGF budgeted for State Operations, $1.6 million was for CBDMP. Reduced funding has caused the program to be drastically restructured. Budget cuts to CPSP has resulted in decreased outreach to promote access to early prenatal care, decreased recruitment and training of new CPSP providers or provision of technical assistance to existing and new CPSP providers. Also, there is reduced monitoring and evaluation of CPSP providers.

>LOCAL MCAH PROGRAMS
The elimination of $2.1 million in SGF from local MCAH programs resulted in a loss of $2.1 million in Title XIX federal matching funds. Total local MCAH funds lost as a direct result of the elimination of SGF and the related Title XIX federal match was $4.2 million statewide in FY 2009-10. For every $1 of SGF cut, LHJs have experienced an additional $1 in Title XIX matched funding. Statewide, in addition to the loss of SGF and the related Title XIX match, local funds budgeted were reduced by $1.9 million in FY 2009-10. Title XIX match to local funds will be affected by the reduction in local funds, and is estimated to be a reduction of approximately $600,000, based on projected invoices.

/2012/The reduction to Federal Title V allocation to the State did not affect local MCAH program budgets for SFY 2011-12, and there were no shifts in funding from MCAH to other Title V programs. SGF remains at zero, and both state and local agencies continue to operate with less money and staff due to hiring freezes and lack of funds.//2012//

>AFLP
In 2009-2010, $10.7 million SGF and $5.1 million related Title XIX were eliminated for AFLP. In the 2009-2010 fiscal year, AFLP reductions resulted in 12,027 fewer clients served -- a 70% reduction in clients served. AFLP agencies experienced staff reductions of 170 full-time equivalent (FTE) statewide. Three AFLP programs -- Riverside, San Bernardino, and Siskiyou Counties -- have been discontinued in FY 2009-10 as a result of their inability to continue activities at the current funding levels.

/2012/Due to a reduction to the Federal Title V allocation to the States in FFY 2011, the total AFLP allocation to local agencies for SFY 2011-12 has been reduced by $250,000. This will reduce the number of clients served by AFLP agencies and put further stress on local programs, which are reported to be experiencing increasing demands for services due to funding reductions to or elimination of other programs like California's CalLearn Program, which provides related

services to the AFLP population. //2012//

/2013/ In FFY 2012, 2 AFLP sites discontinued operations. Funding for AFLP programs will be reduced by $1,900,000 through reductions to local assistance resulting in 13,435 fewer person-months of service in FFY 2013.//2013//

>Black Infant Health Program (BIH)
The 2009-2010 California budget eliminated $3.9 million SGF and $3.7 million related Title XIX to BIH programs statewide. Budget reductions have caused two sites, Riverside and San Bernardino Counties, to close.

/2012/Due to a reduction to the Federal Title V allocation to the State in FFY 2011, the total BIH allocation to local agencies for SFY 2011-12 had been reduced by $140,000. These reductions add to the difficulties faced by local agencies due to the loss of the SGF in SFY 2009-10 and continued lower revenues from state realignment funds.//2012//

>CMS
CMS has lost 30 positions since the 2007 reorganization of DHS into CDPH and DHCS, which together with operating expense reductions, have resulted in unmet workload and backlogs in all CMS programs including CCS. Backlogs for some CCS eligibility determinations and service authorizations in CMS Branch Regional Offices that support dependent county CCS programs now exceed three months. As county revenues from sales, vehicle licenses, and property taxes have declined, counties have been unable to support baseline levels of services in their public health, public assistance, and safety net health care programs. The State's actions to contain expenditures, including 189 capping allocations of local assistance funds for CCS county administration and the CCS MTP, have exacerbated these challenges. County CCS programs maintain that the reimbursement they receive under these funding caps is inadequate for case management and care coordination, and they are cutting staff by attrition and layoffs. Some providers report that eligibility determination and authorization delays, along with the unavailability of CCS staff to assist them with claiming and reimbursement problems, may force them to stop participating in the CCS program. As with many other essential safety net programs, CCS is having difficulty meeting the needs of the CSHCN population. DHCS is working with CCS stakeholders to redesign the CCS program to more efficiently and effectively provide services to CSHCNs while maintaining access, quality of care, and optimal outcomes.
/2013/ CMS will see a reduction of $200,000 in administrative costs and $405,000 will be reduced from HRIF. //2013//

> Budget Outlook
All signs point to another tough budget year for California for 2010-2011. The governor had included $6.9 billion in federal dollars in his January budget plan, but so far the state has received just under $3 billion. The state was hoping for unexpected gains in state revenues to significantly cut the budget deficit. However, revenues from personal and corporate taxes fell $3.6 billion short of what was projected for April 2010 the month when the bulk of revenues are collected. A significant carryover of losses from 2008 to 2009 that brought down revenues from capital gains and weakness in small business income partly explains the shortfall. That means the state's budget deficit, which at the start of 2010 was projected at $20 billion and dipped to about $18.6 billion after some midyear actions by the Legislature, could exceed the original estimate. And state legislators have stated that they do not intend to seek higher taxes this year to bridge the gap. This leaves lawmakers and the governor to face decisions such as the wholesale elimination of certain programs. More than ever, California faces the specter of this being the most damaging year for the health of children, the poor and the disabled.

Recent budget actions and proposals have targeted cutting MediCal services, HF and safety-net programs for low-income women, children and those with disabilities. CalWORKS, the state's version of TANF, provides cash assistance for low-income families with children, while helping

parents find jobs and overcome barriers to employment. CalWORKs is primarily a children's program: Kids make up more than three out of four recipients (77.9 percent), equivalent to 1.1 million of the more than 1.4 million Californians who are projected to receive CalWORKs cash assistance in 2010-11. Women comprise more than three-quarters (77.7 percent) of all adult recipients, and women make up an even larger share (92.5 percent) of single parents who receive cash assistance. The SSI/SSP Program provides cash assistance to help low-income seniors and people with disabilities meet basic living expenses. More than half (57.3 percent) of SSI/SSP recipients are women, equivalent to approximately 666,500 of the 1.2 million adults who are projected to receive SSI/SSP grants in 2010-11. The In-Home Support Services (IHSS) Program helps low-income seniors and people with disabilities live safely in their own homes, thereby preventing more costly out-of-home care. More than three out of five IHSS recipients (63.1 percent) are women and girls, equivalent to approximately 300,500 who are projected to enroll in IHSS in 2010-11. Women also make up the majority of caregivers that receive IHSS employment. IHSS provides a range of services, including assistance with dressing, bathing, and medications in addition to domestic tasks such as cleaning, shopping, and meal preparation. Women comprise more than three out of five adults enrolled in the major safety-net programs that provide these benefits and services.

Medi-Cal, the state's version of Medicaid, provides comprehensive health coverage to 7.2 million Californians, including reproductive and prenatal care, and is a key component of California's safety net for low-income families. Women comprise nearly two-thirds of adult enrollees in the program. In addition, more than half of women enrolled in the program are in their peak reproductive years, a period where women seek more health services than men. Medi-Cal is also an important source of affordable coverage for unmarried women and their children. Nine out of 10 single parents enrolled in Medi-Cal are women. Because women make up a large share of adult Medi-Cal enrollees, women and their children are disproportionately affected by reductions to the program. State lawmakers made significant cuts to MediCal, CalWORKs, SSI/SSP, and 190 IHSS in 2009. Governor Schwarzenegger's Proposed 2010-11 Budget in January 2010 includes even deeper reductions to these programs to help close the budget gap identified by the Governor in January.

Nearly one million children and teens in California depend on HF, the state's version of SCHIP, a federal-state partnership for working poor families. HF was launched in 1998 for parents who earn too much to receive Medi-Cal coverage but who are priced out of the private insurance industry. One way for California to keep programs alive, including HF is getting the $6.9 billion in federal funds. Since California has not received the anticipated federal dollars, the threat to eliminate HF based on the May revise budget proposal is becoming more imminent. These health and safety net programs are not administered by Title V although Title V funding is used to support the maternal and child health needs of populations that utilize these programs. The wholesale elimination of certain programs for children, the poor and the disabled will further exacerbate and create additional challenges for existing Title V administered programs to meet the needs of the vulnerable population it serves.

/2013/ The State's budget shortfall for FY 2012/13 stands at $15.7 billion.

The State's economic recession hit single women supporting families particularly hard with the largest decline in their average workweek in at least two decades. [54]

Funding for K-12 schools can have an additional $5.6 billion dollars in cuts by November 2012 if the tax initiative to increase state taxes is not passed.

Continued shortfalls threaten programs and services that California's women and their families depend on. The budget contained proposals for downsizing and achieving efficiencies including reorganization of State government , elimination of some 700 legislative reports and staff furloughs.//2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.